CUMBERLAND COUNTY COUNCIL
EDUCATION COMMITTEE

The School Health Service

1970

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INDEX

PREFACE

To the Chairman and Members of the Education Committee:
Mr. Chairman, Ladies and Gentlemen,

I have the honour to present the Annual Report on the School Health Service for 1970.

First it must be said that in the relatively short period of time from the last report, there is no significant difference in the numbers of children with defects and that there is evidence that the infestation of the school child in Cumberland is decreasing. In short the school children of this county continue to enjoy robust good health as in the immediate past.

I also continue to be impressed by the magnificent involvement of school children with help to others belonging to inadequate groups of persons i.e. the elderly, the mentally disordered and the physically handicapped. This help is invaluable in the formation of a healthy community attitude, and a great debt of gratitude to you and your Committee and the Director of Education is owed in this matter by the community. I am also glad to say that increasing provision is now being made in ordinary schools for handicapped children by facilities such as ramps for wheelchairs etc.

Now I come to the period of transition of the administration both of local government and the national health service. Change, however necessary, brings in its train difficulties of an interpersonal nature and in the future the need for combined schemes in parts of the service on the fringe of local authority and other health services is already becoming clear to me. The integration of the national health service must produce a better school service and to do this those engaged in it must be part of a wide professional caring team. The "dual economy" in the school health service which was mentioned last year continues and, in fact, has been expanded in that a pilot scheme has come into being where general practitioners carry out medical examinations prior to school entry. Some 15% to 20% of all school examinations are now carried out by general practitioners in this county and this trend is leaving the school medical officers more time to concentrate on developmental screening tests.

As a medical administrator or community physician I realise that I must think in terms of comprehensive health

planning in this area and it seems to me that total medical care should be based on the continuing care of the general practitioner group team.

The computer call-up of children in this county for vaccination and immunisation is now proceeding apace and I feel increasingly confident about the state of protection enjoyed by school children. The year has seen the introduction of Rubella vaccine to the group of thirteen year old girls in school and it is expected that within some few years this should diminish the number of visual and auditory handicapped children in schools.

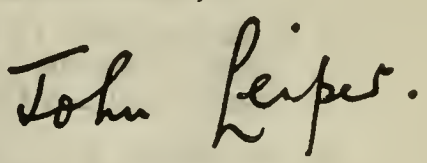
The dental state of children in the Western area continues to be influenced by the adjustment of the fluoride content of the water supply and it is expected that this will content of the waer supply and it is expected that this will be clear to observation and inspection in the next two or three years.

The following pages show the general work of the school health service during the year, which is one of which we can all be proud, as indeed we can of the continuing good health of the school child.

My thanks go to my deputy, Dr. J. D. Terrell, for the preparation of this report, and to all members of the Health Department for such hard work during the year in which so much has been accomplished.

I am, Mr. Chairman, Ladies and Gentlemen,

Your obedient servant,



Principal School Medical Officer.

County Health Department,
11, Portland Square,
Carlisle CA1 1QB.
April, 1971.

SCHOOL HEALTH STAFF

AS AT 31st DECEMBER, 1970

SCHOOL MEDICAL AND DENTAL STAFF

Principal School Medical Officer—

*J. Leiper, M.B.E., T.D., M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.

Deputy Principal School Medical Officer—

*J. D. Terrell, M.B., Ch.B., D.P.H., D.C.H.

Area and District Medical Officers—

C. A. Bentley, B.A., M.R.C.S., L.R.C.P., D.P.H. (Northern Area Medical Officer). Also Medical Officer of Health, Border Rural District Council; Penrith Rural District Council; Penrith Urban District Council and Wigton Rural District Council.

*J. Connolly, M.D., D.P.H. (Deputy Northern Area Medical Officer). Also Deputy Medical Officer of Health, Border Rural District Council; Penrith Rural District Council; Penrith Urban District Council and Wigton Rural District Council. (Appointed 16.2.1970).

*A. Hargreaves, M.B., Ch.B., D.P.H. (Western Area Medical Officer of Health). Also Medical Officer of Health, Cockermouth Rural District Council and Urban District Council; Keswick Urban District Council; Maryport Urban District Council and Workington Borough

J. R. Hassan, M.B., Ch.B., D.Obst., R.C.O.G., Medical Officer of Health, Alston with Garrigill Rural District Council and General Practitioner.

*H. M. Marks, B.A., M.B., Ch.B., D.P.H. (Southern Area Medical Officer of Health). Also Medical Officer of Health to Whitehaven Borough and Ennerdale and Millom Rural District Councils

*L. H. Thacker, M.B., B.S., B.M.S., D.A., D.P.H. (Commenced 1.10.70) (Deputy Southern Area Medical Officer), also Deputy Medical Officer of Health to Whitehaven Borough and Ennerdale and Millom Rural District Councils.

Medical Officers in Department —

*J. E. Ainsworth M.B., Ch.B.
*J. E. M. Garland, M.B., Ch.B. D.P.H.
*M. P. McMillan, M.B., Ch.B.
*Approved for the ascertainment of educationally sub-normal children.

Principal School Dental Officer—

R. B. Neal, M.B.E., T.D., L.D.S., R.C.S.

Area School Dental Officers —

I. R. C. Crabb, L.D.S.R.F.P.S.
A. M. Scott, L.D.S.

School Dental Officers —

D. Allan, B.D.S.
K. M. Burnett, B.D.S.
J. Colvin, L.D.S.
A. Corkhill, B.D.S.
A. B. Gibson, B.D.S.
F. H. Jacobs, L.D.S.
A. R. Peck, L.D.S.

Dental Auxiliary—

Miss R. Kirkwood.

MEDICAL AUXILIARY STAFF

Screening Assistants —

Miss S. Easterbrook.
Miss D. Kidd.
Mrs. J. Laidlaw.

Orthopaedic Physiotherapists —

Mrs. P. P. Bratt, M.C.S.P. (part-time)
Miss M. Sivewright, M.C.S.P., O.N.C. (part-time).

Orthoptists —

Mrs. J. A. M. Payne, D.B.O.
Mrs. J. Scott, D.B.O. (part-time).

Senior Speech Therapist —

Mrs. E. M. Blacklock, L.C.S.T.

Speech Therapists —

Mrs. J. Lahiff, L.C.S.T. (commenced 13.7.70).
Miss E. B. Moon, L.C.S.T. (part-time).
Mrs. S. Latimer, L.C.S.T. (part-time).
Mrs. M. E Ogram, L.C.S.T. (part-time).

NURSING STAFF

Chief Nursing Officer —

Miss K. J. Hayes, S.R.N., S.C.M., H.V. Cert.

Deputy Chief Nursing Officer —

Miss J. Byatt, S.R.N., S.C.M., M.T.D., Q.N., H.V. Cert.

Area Nursing Officers —

Miss J. Reid, S.R.N., S.C.M., Q.N., H.V. Cert. (Southern Area).

Miss J M. Crossfield, S.R.N., Q.N., H.V. Cert. (Western Area).

Mrs. J. M. Roberts, S.R.N., S.C.M., Q.N., H.V. Cert. (Northern Area).

Nurses' Qualifications Code

1. State Registered Nurse (or Registered General Nurse).
2. State Certified Midwife
3. District Nursing Certificate.
4 Health Visitor's Certificate
5 Registered Fever Nurse.
6. Registered Sick Children's Nurse.
7. Orthopaedic Nursing Certificate.
8. State Enrolled Nurse.

School Nurses —

Full time

Miss B. M. Wesson, 1, 2, 3 Northern Area

Part-time

Mrs. M. I. Carrick, 1	Maryport
Mrs. K. Crook, 1	Workington
Mrs. M. E. Frain, 1	Cockermouth
Mrs. M. E. Sansom, 1, 2	Workington
Mrs. V. Burrows, 1	Seascale/Frizington
Mrs. A. Corkhill, 6	Cleator Moor/ Egremont
Mrs. M. Nelson, 1	Whitehaven
Mrs. T. Rich, 1	Millom
Mrs. I. Warbrick, 1, 2	Whitehaven

Health Visitors/School Nurses —

Northern Area—Full time

Miss C. M. Bannan, 1, 2, 4	Aspatria
Miss M. M. Butler, 1, 2, 4	Longtown
Mrs. M. Hedworth, 1, 2, 3	Wigton
Mrs. I. Kelly, 1, 2, 3, 4	Penrith
Miss B. W. Knibbs, 1, 2, 4	Brampton
Miss E. A. Lockhart, 1, 2, 3, 4	Carlisle & Border
Miss K. M. Rigby, 1, 2, 4	Penrith
Miss D. Roulstone, 1, 2, 4	Penrith
Miss P. B. Simpson, 1, 2, 3, 4	Dalston/Thursby

Part-time

Mrs. B. Buchanan, 6	Longtown
Mrs. M. Dobson, 1, 2, 3, 4	Brampton
Mrs. D. Edmondson, 1, 2, 4	Lazonby
Mrs. A. Gallacher, 1, 2, 4	Brampton/Alston
Miss E. Henderson, 1, 2, 3, 4	Caldbeck
Mrs. D. Lancaster, 1, 2, 3, 4	Kirkbride
Mrs. M. McCredie, 1 2, 4	Lazonby
Mrs. M. J. Matthews, 1, 2, 3, 4	Watermillock
Mrs. E Woolley, 1, 2, 3, 4	Brampton

Western Area—

Full time

Mrs. A. E. Campbell, 1, 2, 4	Keswick
Miss G. Davies, 1, 2, 3, 4	Workington
Miss A. Dixon, 1, 2, 3, 4	Cockermouth
Mrs. J. A. Graham, 1, 2, 3, 4	Workington
Mrs. M. Hewitson, 1, 2, 4	Workington
Miss A. Jackson, 1, 2, 4	Workington
Mrs. M. Lythgoe, 1, 2, 4	Cockermouth
Miss E. J. Surtees, 1, 2, 4	Workington
Mrs. H. G. Watson, 1, 4	Workington
Mrs. L. Williams, 1, 4	Maryport

Part-time

Miss M. Casey, 1, 2, 3, 4	Keswick
Miss M. P. Reynolds. 1, 2, 4	Cockermouth
Mrs. A. M. Wandless, 1, 2, 4	Workington

Southern Area—

Full time

Miss I. M. Alcock, 1, 2. 4	Whitehaven
Mrs. W. Batey, 1, 4	Whitehaven
Mrs. S. Crellin, 1, 2, 4	Whitehaven
Mrs. A. Petch, 1, 2, 3, 4	Whitehaven
Miss A. Singleton, 1, 2, 4	Whitehaven
Mrs. A. Donald, 1, 2, 3, 4, 7	Ennerdale
Miss M. E. Gibson, 1, 2, 4	Ennerdale
Miss A. Parkinson, 1, 2, 4	Ennerdale
Miss R. Sheppard, 1, 2, 3, 4	Ennerdale
Mrs. I. Bowe. 1, 2, 3, 4	Millom
Miss M. Robinson, 1, 2, 4	Millom
Mrs. P. Fitzgerald, 1, 2, 4	Ennerdale

Part-time

Mrs. M. Cutler, 1, 2, 4	Seascale
Mrs. M. Moorhouse, 1, 2, 3, 4	Millom

Dental Surgery Assistants —

Miss M. I. Stout Senior Surgery Assistant.
Mrs. E. M. Byers.
Mrs. V. A. Clark.
Miss M. Fitzsimmons.
Mrs. M. Griffiths.
Mrs. E. Hocking.
Miss M. Kennedy.
Mrs. W. F. Reeves.
Mrs. J. Smith.
Mrs. D. M. Tasker.
Miss P. M. Taylor.
Miss J. Townson.

GENERAL STATISTICS

The number of pupils on the school registers on 22nd January, 1971 was 40,334 compared with 39,897 in the previous year, an increase of 437.

In January, 1971 there were in the County:—

	No.	Pupils
Nursery Schools	1	40
Primary Schools	216	23,663
Non-selective Secondary Schools	3	1,599
Grammar Schools	2	907
Comprehensive Schools	27	14,016
Residential Special Schools	2	109
(one for E.S.N. Boys, 9-16)		(71)
(one for E.S.N Girls, 9-16)		(38)

THE SCHOOL HEALTH SERVICE

I commented in my Annual Report last year on the then impending proposals for administrative changes in the National Health Service, and anticipated as far as possible some effects on the school health service. Since then, of course, governmental changes have inevitably delayed the emergence of any firm proposals on the health service generally and so there is little further that can be said at present. The very delays themselves are, however, disquieting especially as far as medical staff are concerned, and the recruitment of public health doctors, administrative, and clinical, could be critical in the near future. It is still on these that the medical work of the school health service largely depends although family doctors are gradually being introduced more widely into the child health service. This report on a later page contains the very preliminary comments of the Northern Area Medical Officer on the scheme now operating at Penrith and Longtown in which a group of family doctors are undertaking a pre-school entry medical examination of the children of their own practice to be followed by further screening by teachers and others in school. Also, a scheme is being prepared at the moment for the family doctors in Keswick to assume responsibility for the selective medical examinations of the children of their practices. This particular scheme is the first one where the general practitioners will be seeing the children in the practice surgeries and one of the features of the scheme is the careful arrangement of adequate general health advice to the heads of schools and the system whereby appropriate communication is maintained between each doctor involved and the school heads about individual children. Administrative and clerical support will continue from the Western area health office.

The essential unity of the child health services has been the principal theme of all my recent reports and I mentioned last year the initiative of the North of England Paediatric Society in promoting local discussion groups on this topic. This was a most illuminating and stimulating exercise during 1970 and the report of the groups including the Cumberland and Carlisle group was presented to a plenary session of the Society in October in Newcastle. The Cumberland geographical area lent itself to consideration of a more truly integrated child health service for the future and it was most encouraging to find a wide area of agreement between public health doctors, paediatricians and the few general practitioners who took part in the discussions. An integrated child health service based on the department of child health in a district

general hospital would provide all of the elements of the service at present provided by local authorities in close conjunction with group practices. While such a service could only function fully in the context of a re-organised and unified health service, much can be done now to prepare for this, including the special training in developmental paediatrics and other specialised aspects of the work, of selected local authority medical officers. Furthermore it is to be hoped that the hospital service similarly will be considering how their staffing situation can be adjusted to be in a position to meet the new challenge. An important move in this direction has been the appointment during 1970 of the first consultant child psychiatrist in the Special Area of Cumberland and North Westmorland. I comment further on this in the report on the child guidance service.

Meantime recent consideration was given to the development envisaged in the school health service for the remaining years of its life within the local authority. Principal objectives were prepared by all departments for the consideration of the County Council's Co-ordinating Committee and from the Health Department these included the following points directly relating to the school health service:—

A fully integrated diagnostic and advisory child health service from birth to school leaving age making maximum use of general practitioners' services in clinical work. All children to have regular pre-school medical screenings, thereafter on a selective basis. Four specialist senior medical officers will be required full time within the department when family doctors deal with all routine work. Child health clinics to be conducted in group practice centres with specialist clinics conducted in six centres in the county.

The dental service aims to screen all children at three years of age and annually from school entry.

Vaccination and Immunisation: 100% cover of the child population by general practitioner teams in protection against all the infectious diseases included in the current schedule of vaccination and immunisations recommended by the D.H.S.S. and to this end making maximum use of automatic data processing.

Commencement of a school chiropody service to the scale of work by whole time equivalent of two chiropodists.

To provide a health education service through a section staffed by a health education officer and two clerks to initiate health education activities and support doctors, nurses and others in this field.

I always like in this annual report to include early impressions of doctors who have joined the school health service and have had a reasonable time to form opinions on the work. Fresh thoughts and ideas are the life-blood of any service and I am glad to record the following comments by Dr. McMillan, Medical Officer in Department in the Southern Area:—

"An outstanding feature of my first year as a School Medical Officer has been the opportunity to attend the course in London for the assessment of educationally subnormal children. Apart from acquiring the necessary training to perform Stanford-Binet intelligence tests and complete a 2 HP form, we were given lectures on demonstrations on the care, assessment and education of many types of mentally and physically handicapped children.

I feel that in future more of the School Medical Officers' time will be taken up with the educational problems of the handicapped child, especially in view of the new regulations, which will in April 1971, end the classification of some children as unsuitable for education. At the same time, a survey has begun of children on the physically handicapped register who will require education in the next two or three years, especially with a view to the type of education they will require, whether it can be given in a normal school and, if so, what extra help, e.g. transport, provision for a wheel chair, etc. will be needed.

As a corollary of this work it is felt that it would be a help to have a scheme of developmental screening of children on the handicapped or at risk register, from birth to four and a half to five years of age, so that progress, special difficulties, and general ability would be recorded, probably in conjunction with the developmental questionnaires and hearing tests already used by the health visitor. This information would be available at, or before the five year school medical examination.

This examination at present forms the basis of future follow-ups of children during their school career, with the help of intermediate selective medical examinations and regular review of any defects found.

The other routine school medical examination at thirteen years of age does not yield a great deal of new medical information. At this age the children do not know their future and cannot be properly medically assessed as to future career or occupation. This will be even more marked when the school leaving age reaches sixteen years in the school year 1972 and 1973.

Throughout the year I have enjoyed meeting the staffs of the various schools I have visited and have found them most helpful and observant. In the larger secondary schools it has been more difficult to contact staff who really know of a particular child's progress, but the house system eases this problem in some of them.

It was felt during the year that at least part of the continuing problem of head infestation was due to parents being unaware of the risk, and the need for regular vigilance. Accordingly a letter was printed and distributed to all children at several schools where the nurses had reported an increase in this problem and parents have recorded their appreciation of this.

The problem of the overweight child has also been prominent, especially among senior girls and I have endeavoured to provide diet sheets and individual advice to these children, and in one instance to institute a school "weight-watchers" scheme, with the help of two members of staff".

On the highly important topic of communications within the School Health Service, Dr. Bentley, Northern Area Medical Officer, makes the following comments:—

"During the Autumn term an attempt has been made throughout the area to improve communication between the health team and teachers and parents generally. To be efficient through the years between school entry and school leaving selection must encourage the examination of children with problems at all ages. Instead of being circularised with health questionnaires only when children are 8 years and 12 years of age, parents are now circularised also when the "re-inspection" type of selection is arranged, i.e. the examination of children previously marked as for treatment (T) or for observation (O) Routine communications to parents of entrants and selected pupils have also recently emphasised that they may have their child listed for a termly medical examinaion at any time that they consider this to be necessary.

Head teachers (and through them the class teachers) have been sent a letter reminding them that the School Medical Officer is available to visit each term and informing them of the problems that the School Health Srevice is most concerned to hear of. A simple form has been issued to them for easy referral of children with health problems. Each term the health visitor visits the school to collect the referrals and to deal with the problems which arise. In some cases normal health visiting skills are adequate to deal with referral needs of the child, but in other cases the child's problems are dealt with by the School Medical Officer at a term visit.

Larger schools are to be visited routinely by the Medical Officer every term, but in the smaller schools selection visits will be undertaken at the annual medical examinaion or at other terms where there is a demand. This policy is necessary in this area because the very large number of remote smaller schools would make term visits to all schools a practical impossibility.

Health visitors and other members of the health team can and do make a valuable contribution of cases for the Medical Officer to see on his visits to schools. This includes cases referred by the family doctor. As far as possible health visitors are associated with certain groups of schools roughly appropriate to the practice areas of their family doctor attachments. School Medical Officers are associated with areas involving groups of health visitors.".

Medical Examinations

Considerable thought has been given in the past year to the form of school medical examinations, particularly the school entrant and leaver examinations. The general direction of these thoughts is indicated in the following contributions from Dr. Connolly, Deputy Northern Area Medical Officer, and Dr. Ainsworth, Medical Officer in Department, Western Area. Both deal especially with the particular significance of the school entrant examination. Writing of the early days of the pilot scheme in the Northern Area, Dr. Connolly comments:—

The school entrant medical examination is the most important medical examination now conducted at school. During the year consideration was given to some improvement in the pattern of examination using the resources available.

The school entry medical to be thorough is a time consuming exercise. It is desirable that not only should there be an examination for physical defects but also that mental or neurological factors and environmental factors affecting motivation should be taken into account. Ideally all the work should be carried out by Medical Officers highly trained in developmental paediatrics. However, it seems unlikely that in a time of medical manpower shortage it will always be possible to have a sufficiency of Medical Officers in Department of whom enough have a suitable background in developmental paediatrics to cover the task adequately. In the context of the unification of the Health Services it would also seem to be sound policy to involve general practitioners as fully as possible in the examination of their own patients.

With these ideas in mind it was considered that the aims could be met by a pre-school entry medical examination at the age of 4½ years, carried out by the child's own general practitioner in his surgery followed by some screening procedures at school. Children screened out could be given more time and consideration at selective medical examinations. Medical Officers in Department could concentrate on selective work which increases their clinical interest and makes recruitment easier. Screening would involve during the child's first two school terms — an audiogram, a visual acuity test, a five year old milestone assessment completed by the child's class teacher and a questionnaire to be completed by the child's parents. This whole process would be followed by selective examination of children by the School Medical Officers during term visits Their selection would be based on:—

(a) Appropriate health visiting records and at risk or observation records.

(b) The completed pre-school medical examination.

(c) An audiogram.

(d) A visual acuity test.

(e) A completed five year old milestone assessment.

(f) A completed parental questionnaire.

With these objectives a pilot scheme was set up in three separate districts. This involves seven general practitioners, four in partnership together and three single

handed general practitioners. In these practices since September, 1970, the school entry medical examination has been replaced by a pre-school entry medical examination for children as they reach 4½ years. The follow-up screening procedures on these children will take place at school during 1971. The scheme will be fully reviewed at the end of one year. The practices involved are at Longtown (two family doctors), High Hesket (one family doctor) and Penrith (four family doctors). The results of examinations carried out so far are shown in the table on page 20.

The disadvantages encountered so far in the pilot scheme have been:—

(1) The initial lack of familiarity of family doctors with the 10.M. school health record form. These minor difficulties have now been overcome.

(2) All family doctors approached showed an interest in the pilot scheme and did agree to participate. However, it is likely that some family doctors would not wish to participate if this scheme became a general arrangement. In this case children from these practices would have to continue to be examined by school doctors in the traditional way.

(3) So far all the parents invited to bring their children to the surgery have done so, but if they failed to attend as may occur these also would have to be seen by the School Medical Officer in the traditional way.

(4) Some children come to live in the area above the age of 4½ years who have not had the school entry examination, and some arrangement would have to be made to have these children examined either in the surgery or at school

The advantages appear to be:—

(a) The general practitioner in association with the attached health team appears to be in a better position to assess the physical condition and home factors in children who are attending from his own practice. This seems preferable to the situation where the Medical Officer in Department sees the child for the first time for a short period in a strange environment.

(b) The general practitioners concerned have welcomed the scheme for it gives them an opportunity which they would otherwise not have of giving a full examination to all their child patients. It also prevents the slightly embarrassing situation from arising whereby, through no fault on the part of the general practitioner, a physical defect in one of his patients may be first discovered by the School Medical Officer.

(c) The scheme does not involve general practitioners in seeing any children who are not their patients. This would happen where they are employed on a sessional basis in schools.

(d) The general practitioner's surgery is a better environment than school for carrying out other screening procedures which might be introduced later, e.g. urine tests.

(e) A fee is payable to the general practitioner on the basis of one session per twelve children examined, but these children are not necessarily seen all at once and the load is usually spread over a number of normal surgery attendances.

(f) The number of pre-school medical examinations per general practitioner in the area is approximately thirty to forty annually. This is no a large burden for the practice.

(g) Plans have already been made for appointments to be arranged at 4½ years through the County's computer scheme with a view to immunisation, booster immunisations against poliomyelitis, diphtheria and tetanus. This could readily include the appointments for a pre-school medical examination.

(h) The scheme has been welcomed by parents, who prefer to see their familiar family doctor rather than an unknown or little known School Medical Officer.

(i) The scheme has been welcomed by teachers because there will eventually be less disruption to school work with large numbers of routine entrant examinations.

(j) The visitation of a school doctor and its present association in the child's mind with injection procedures can cause anxiety in children who have just commenced at school.

(k) Most of the teachers concerned are very interested in the introduction of the five year old milestone assessment, although they are not in a position to judge the results. It is felt that this will lead to much earlier selection of children at risk and children with educational handicaps.

DEFECTS FOUND BY SPECIAL MEDICAL INSPECTION OF PRE-SCHOOL CHILDREN AT AGE 4¼ YEARS DURING 1970

Defect Code Number	*Defect or Disease*	*Pre-School*	
		T	*O* *
4	Skin	1	4
5 Eyes	a. Vision	—	3
	b. Squint	2	—
	c. Other	—	—
6 Ears	a. Hearing	—	2
	b. Otitis Media	1	—
	c. Other	—	—
7	Nose and Throat	3	—
8	Speech	3	3
9	Lymphatic Glands	—	1
10	Heart	1	—
11	Lungs	—	—
12	Developmental—		
	a. Hernia	—	—
	b. Other	—	—
13	Orthopaedic—		
	a. Posture	—	—
	b. Feet	2	3
	c. Other	—	2
14	Nervous System—		
	a. Epilepsy	1	—
	b. Other	—	1
15	Psychological—		
	a. Development	1	2
	b. Stability	—	—
16	Abdomen	1	—
17	Other	—	2

Children examined — 39 Boys, 32 Girls.

*T — Treatment; O — Observation.

There are many variations on the theme of improved school entrant examinations suitable for experimentation, and Dr. Ainsworth's thoughts, as given below, take a slightly different direction from those of Dr. Connolly and arise from her wide experience of developmental work with pre-school children. I look forward to Dr. Ainsworth making a start with this approach in 1971. She writes:—

"It is now realised that there is a definite need for a new kind of entrant examination and a need to get away from the type of medical we have carried out in the past. During recent years when one has been asked to comment on the school health service it has become obvious to us all that physical illness as it was when the present type of infant medical was devised is receding and it is now recogised that there are other problems present which need detection.

Various harmful incidents which can occur at birth or in the early days or weeks of a child's life, e.g. light weight for dates babies and incidents in the neonatal period, e.g. apnoeic attacks, hypoglycaemia, etc., are known to produce defects in a reasonable percentage of children. These defects can be major and can produce a disability or a handicap, e.g. cerebral palsy in varying degrees, hemiplegia, etc. On the other hand, these defects can be minor so these children appear outwardly to have no serious defect, but they have minor neuro-developmental defects which can cause a disability or/and a handicap during their school life.

At present great interest and much work is in progress in examining infants neurologically — based on Prechtle's screening — at 7 days, but it is now recognised that infants having had a "perinatal illness", as indicated above, can have defects occurring later which can only be recogised either by neuro-developmental examination at 5+ years or later still when difficulties occur at school.

For several years it has been obvious to me that in the Junior schools children of 8, 9 and 10 years have been brought to our notice because of learning or behaviour difficulties.

In London there is a survey being carried out at present and it is thought that 5% of children at school entry have some type of disorder — learning disorders, including disorders of body image, specific learning difficulties, mental retardation, and disturbance of behaviour — which is related to something wrong with development or with brain function.

Some of these children have neurological signs and others have disorganised development so that their development is not proceeding normally in all parameters. The relation between brain damage and function is very complex.

This, therefore, brings us to the need for a specialised type of neuro-developmental examination at school entry, as this is the only way that children with these disorders can be recognised earlier than we are doing at present. At present it is only when something is really wrong e.g. difficulty with reading, with general learning, clumsiness etc. that the child is brought to our attention and this is usually by the teacher. Hence this new type of examination allows us to assess functions which have developed at 5 years and which were not testable at an earlier age and this allows us to recognise deviations from normal.

Various examples of neuro-development disorders come to mind, e.g., in a hemiplegic child there is a wide gap between verbal development and spatial ability. With low birth weight babies there is a high proportion of blindness, fits, deafness and varying degrees of cerebral palsy. If, in addition to a neuro-developmental disorder, there is a poor environment as well, then these children get into difficulties, and children with neuro-developmental disorders (this term has now replaced "minimal brain damage") are four to five times more at risk than normals to develop behaviour difficulties.

In the Rhode Island study all children who failed first grade were those detected by developmental neurological tests, and these children had either learning or behaviour problems. In another group with school refusal, half had signs of cerebral dysfunction

Epileptic children are a group known to have more problems, and the same holds true of boys with undescended testicles, as this could be one manifestation of abnormal development, e.g. 50% of children with cerebral palsy have undescended testes.

It is important for doctors to be involved with young children before and after school entry, because of their special knowledge of these problems. I also feel that doctors with special training and knowledge about the development of children should retain this specialised type of new entrant

examination after the routine medical inspections, in the reconstructed National Health Service, pass over to the family doctors.

I think, unlike the Plowden recommendation, that *at present* it is more satisfactory to do this examination after school entry rather than pre-school at $4\frac{1}{2}$ years. This view is also held by some who are doing this examination at present. The captive audience at present is at school entrance, but in addition there is the most valuable information one can obtain from the teachers. My view is that after this comprehensive entrant examination, if the child is found to be normal it is not necessary to see this child again at school unless asked by the parent, teacher, child, health visitor, nurse, or other. If, however, the child is found to be suspect, then after this precise test it can be reviewed and its progress watched and help offered early where it can be given.

Following this specialised examination, the medical officer should see the teachers. It is difficult to know at this stage of developing this new examination, the best way to involve the teachers, but by this examination the child with these disorders can be identified and its assets and deficiencies assessed. By the running of a joint clinic for difficult cases, a service could be developed with the educational psychologist to help to interpret these problems and then the teachers could be advised what they could do or informed that certain children have special difficulties. Even by merely explaining to the teacher that a child has certain assets, deficiencies and/or disabilities, and by making her aware, he can be helped enormously in tolerance and understanding, to reduce the child's difficulties.

A new type of entrant neuro-developmental examination has just been worked out in this Area, but it is not yet in use. This involves firstly a parental questonnaire to be completed, with the help of a nurse, to obtain information about the history of the child, which includes:—

1. Birth history and perinatal behaviour;
2. Medical developmental history in the first 4 or 5 years of life;
3. Illnesses and present health — child and family history;
4. Social relations and behaviour.

At risk factors in a child's history would make one more alert for neuro-developmental disorders possibly being present. A very useful vision test for 5 year olds is the Sheridan Gardner Test. Also, although it is necessary to have audiometry done by a trained audiologist prior to the medical, it is not an adequate test of a child's ability to listen, although it is adequate test for hearing. In this new kind of medical the child's ability to listen is tested, which was not done in the old type of examination.

The examination itself includes a physical examination, and a finding of undescended testes is an alerting factor to other abnormalities. In addition to this, a selection of tests are carried out to examine the child developmentally and also to examine the neurological system, e.g. sensory perception tests, reflexes, hand function and hand movements, and tests for associated movement. A child who just fails one test raises one's suspicions, but if more are failed then one can build up a picture of the child's difficulties.

This entrant examination, which should be fully comprehensive, is in itself a screening of those with difficulties or disabilities as soon as a child starts its school life and alerts one as to which children require watching and/or further attention.

After doing selective medical inspections for some time, I am very much in favour of continuing to select at 8 years and 12 years of age. It seems to me that the only disadvantage of this method up to date is that we have not sufficient time to make more frequent visits to each school, and I feel we can only gain this time by stopping routine leavers examinations We are examining at the leavers examination large numbers of normal children and I think there is a case for the introduction of selective medical inspection for this group as well".

Dr. Marks, Southern Area Medical Officer, makes the following general comments on medical examinations in 1970:—

"All the schools in the area have been visited during the year for the purpose of medical inspections except one Junior school. This school has been closed for modernisation and extensions. The pupils who normally go there have been divided to attend two neighbouring schools; they will be included in the programme for next year as they had missed the dates of medical visits at their temporary schools.

Every child is seen at school entry with an appropriate Form 10M carrying all relevant per-school reports which may be from the hospital consultant or from the health visitor. Defects which are noted are seen later at appropriate intervals Undescended testicles are now referred to the surgical department at a much earlier date. The operation is usually done at about the age of seven years instead of waiting until the boy is eleven or twelve years old.

If a child is selected the parents are invited to attend but there is still confusion in the minds of some parents with regard to their presence at the medical inspection. The parents often turn up for the medical examination expecting a routine examination on all the children of the same age group, but when the system is explained it is fully accepted and in time this problem will disappear.

A compulsory medical examination is carried out at all the secondary and grammar schools on all children about the age of fourteen. At these inspections we see large numbers of normal children. I do feel that the selective system could be justifiably implemented for this age group, thus making time available for the health education programme.

Health Education in the form of "Hygiene Hints" is conducted at the same time as the medical inspection. The individual approach on this subject is sometimes better received than group activity".

Employment of Child Byelaws

Total examined during the year ...	255
Total number of children involved	251

Examined for the first time	Re-examined once.	Re-examined twice.
251	Nil	Nil

School Clinic Work

Despite the fact that the school clinic, which was once the treatment centre for minor ailments, is no longer fully used for this purpose, there is still a need for a limited number of sessions to be labelled a school clinic. A set time is required by the School Medical Officer to offer fuller examinations or re-testing of children. Teachers report problems and an appointment can be offered to see parent and child at the clinic. On occasions, to gain the child's confidence, the clinic is preferable to the environment of school.

Cases of obesity call for weighing before or after school. The clinic deals with developmental problems, skin inspections, foot inspections, vision and hearing tests, vaccination and immunisation procedures, medical examinations for entry to special schools, entry to training colleges, and for the Employment of Children Byelaws.

The figures are once again shown below of the numbers of children attending school clinics, the majority being cases for retesting or fuller examination by the School Medical Officer:—

Clinic	*New Cases*	*Total Attendances.*
Brampton	8	9
Egremont	1	1
Flatt Walks	9	9
Millom	98	114
Park Lane	149	218
Penrith	5	5
Wigton	10	12
	280	368

SCHOOL CLINICS

Defect Code No.	Conditions for which child attended.	New Cases 1970	1969	1968	1967	1966	1965	Total Attendances 1970	1969	1968	1967	1966	1965
1.	Cleanliness	—	—	4	—	5	—	1	—	7	—	5	—
2.	Infestation	14	9	5	3	—	2	28	28	20	13	—	9
3.	Skin disease	7	9	25	40	59	36	11	11	28	80	103	62
4.	Eye disease	128	41	60	112	76	119	144	163	62	129	138	212
5.	Ear conditions	29	10	20	31	81	87	64	33	47	82	157	208
6.	Nose and throat conditions	6	3	8	9	7	14	6	7	11	13	7	20
7.	Speech defects . . .	17	7	25	8	19	26	19	10	28	18	20	30
8.	Lymphatic glands	—	—	—	—	—	2	—	—	—	—	—	2
9.	Heart conditions	—	1	—	1	1	1	—	1	—	1	2	4
10.	Lung conditions	2	—	2	2	3	4	2	—	3	4	4	6
11.	Developmental	10	—	3	1	3	1	12	—	4	1	5	4
12.	Orthopaedic	5	7	13	8	37	38	5	8	13	9	38	49
13.	Nervous systems	1	—	—	2	6	6	1	—	—	3	17	8
14.	Psychological	35	9	17	17	18	18	42	10	23	27	21	26
15.	Abdominal conditions ...	2	2	1	3	4	5	7	4	1	3	4	9
16.	Weight	—	—	5	—	—	—	—	—	11	—	—	—
17.	Other conditions	24	43	21	26	42	56	26	62	45	47	88	69
		280	141	209	263	361	415	368	337	303	430	609	718

SPECIAL SERVICES

In this section of the report I draw together again accounts of the various specialised services available to appropriate school children through the school health service. In three medical specialities consultants seconded by the Regional Hospital Board co-operate fully in a variety of special arrangements for the assessment and treatment of school children. These are opthalmology, ear, nose and throat surgery and psychiatry. Others, the orthopaedic surgeons, give the excellent service they always did but from a more direct hospital base. And the consultant paediatricians co-operate at too many points in the school health service to give any coherent account of our dependence upon them. Similarly, a full range of other non medical specialists are involved in these services including speech therapists, orthoptists, physiotherapists, educational phychologists and social workers.

I have abbreviated this year the account of the audiology service, not because it has declined one whit in importance but purely in an effort to make the report perhaps a little more readable in this respect. I include in full, however, the reports of the two peripatetic teachers of the deaf whose follow-up work in the schools is so vital to the ultimate success of all the widely spread screening and assessment work of the screening assistants, nurses and doctors. It is a matter of great regret that Mr. Abbott, Peripatetic Teacher of the Deaf in West Cumberland, resigned late in the year to take up another appointment elsewhere. I would like to thank him on behalf of the School Health Service for many years of invaluable work in the schools of Cumberland; and to wish him well for the future.

Audiology Service

The table on page 36 gives the detailed figures of cases seen, sources of referral, etc. The 'flesh' is put on this skeleton by the following reports from the areas, including the reports of the peripatetic teachers of the deaf.

Dr. Marks comments:

"In the Southern Area in 1970, 1,245 routine tests were carried out on the school entrants. Only 62 of these children showed any hearing loss. This figure shows a steep decrease over the previous year. Of the 62 children with impaired hearing, 27 had only a slight loss and these are

being kept under observation. Thirty-five had a moderate loss and were called up to a special clinic for more thorough examination. Five of these were referred back to the family doctor for treatment but it was thought advisable to refer 23 to the otologist for a specialist opinion.

In addition to the routine cases, 288 children were followed up. These were children who had been tested in previous years and had been kept under observation. Out of the 288 cases, 153 were found to have recovered completely and now have normal hearing. Seventy-nine had only a slight loss and were kept under observation. Fifty-six were referred to the doctor for more detailed examination and from these 43 were referred to the hospital consultant for an opinion and 3 were sent to their family doctor for treatment.

Of the special cases referred last year by the School Medical Officers, teachers and others, seven were kept under observation, 28 were referred to their family doctors, 43, were seen at a special clinic and 7 were referred to the hospital".

From the Western Area, Dr. Hargreaves, reports:—

"In the current year a total of 1,369 school entrants were tested by routine audiometry in school and 100 (7.3%) were found to have an apparent loss of hearing. Re-testing reduced the number requiring further investigation to 60 (4.4%).

Of 193 special cases referred for audiometry, 65 were tested as part of the total ascertainment in educational subnormality (one child already known to be slightly deaf) and of the balance only 22 cases required further elucidation.

Six children (all male) under school age are under treatment by Otologist and/or Teacher of the Deaf or under special observation. Four have been fitted with hearing-aids.

Of cases discovered before 1970 twenty-five were referred to the Otologist including one severe high frequency case. A hearing-aid is under consideration. Five cases were thought to be insignificant, four reverted to normal hearing and the remainder were treated or kept under observation for conductive lesions including five with middle ear defects.

The total (221) of all school children affected by some degree of deafness dropped by some forty cases compared to 1969 but there was in fact a slight increase in those with moderate losses. At the same time the number of severe cases has dropped slightly and no case with severe deafness in the Western area is due to start school in 1970".

Dr. Bentley reports:—

"The majority of the routine work by the screening assistant during the year has been in testing entrants at school. A total of 1,282 pupils have been tested in this way during the year. 20% of these failed to respond to their first test and 12% on a second failure were referred to the School Medical Officers for advice.

Special cases have come mainly from teachers and head teachers, some of these indirectly through the school medical officers by selection procedures. These special cases although only 186 in number have yielded quite a large number of children requiring expert attention.

By the end of the year 76 children remained under the observation of the screening assistant, the majority were minor cases. All had been fully discussed with the school Medical Officer.

Sixty-seven pupils are undergoing examination or are for further selection by school Medical Officers. Thirty-two have been referred to Ear, Nose and Throat Consultants with the approval of their family doctors.

Twelve children have had the help of the Teacher for the Deaf, but all of these had also been seen by Consultants in Ear, Nose and Throat Surgery. Forty children showed a complete and spontaneous recovery of normal hearing or had left the area by the end of the year"

Miss Cronie, Peripatetic Teacher of the Deaf in the Northern Area, writes as follows:—

Pre-school children:

Fifty-six babies and pre-school children have been seen this year, of whom ten were under observation or treatmnt last year. They were referred by Health Visitors (30), G.;Ps. (2). M.O.H. (2), Parents (3), Children's Officer (1), Speech Therapist (5) and the Consultant Paediatrician (3).

Of these, three have now started school and are included in that group. Forty-two have been screened, one is profoundly deaf after illness, six have partial losses and four are under observation. Three of the latter have mental handicaps which has made even simple screening tests difficult to carry out.

The profoundly deaf boy in this group last year was admitted to special school in October and settled very quickly. The close contact maintained between school and home has made the move much easier for parents and child.

Profoundly deaf	1
Partially deaf	6
	7

Children at special schools:

There are eleven children from this area at special schools. One girl was withdrawn by her parents in July because they felt she had not settled well at school. There had been no previous mention made that this was happening-as far as those in school were aware she had presented no special problem in settling down. She has now been enrolled at a private school where she is making a little social progress although she is handicapped too severely by her hearing loss to be able to cope in an environment suited to children with unimpaired hearing.

The other children in this group appear to be making satisfactory progress. The younger ones particularly benefit from having every weekend at home; there are five children in the 3 to 8 age group, all of whom come home at weekends.

One of the girls spent a week at a holiday camp with her mother during the summer. This was provided by the National Deaf Children's Society and was much enjoyed by both.

I spent a very pleasant week at Northern Counties School for the Deaf in May. Most of the time was spent in the Infant/Nursery Department, observing and teaching. It was an excellent opportunity to see how the children from this area had settled and to discuss their progress in and out of school, with teachers and domestic staff. It was also of great benefit to be with other teachers of the deaf, since

most of my time as a peripatetic worker in this field is spent in isolation from other members of the profession.

Children in ordinary schools:

Four children have left school, two for further education courses and one to start an apprenticeship. The fourth has a dual handicap and is under welfare supervision

Three children have moved from the pre-school group; one has now been screened, one has a unilateral loss and is under observation. The third is severely deaf and awaiting admission to special school. She has been issued with a hearing aid with bilateral receivers and has settled well in her local school, although unable to make much progress because of the difficulty in communication due to poor hearing and lack of language.

Three children who were under observation in this group last year have now been issued with Medresco post-aural aids and are benefiting from them. Two five-year olds who were found to have severe losses on school entry screening tests have also been given post aural aids and are beginning to make a little progress with them. Twelve children are under observation, without aids at present but requiring some supervision and help. A boy with a hearing aid has moved into the area from Wales.

There are thirty-five children in this group. Help has been given in auditory training, speech improvement, lip-reading practice, and remedial work in school subjects mainly English and Mathematics. Hearing tests have been carried out and the table shows the loss in the better ear, averaged over the main speech frequencies.

Up to 30	decibels	8
30 — 40	,,	10
40 — 50	,,	6
50 — 60	,,	6
60 — 70	,,	2
over 70	,,	3
		35

There have been many opportunities this year for talks about the handicap of deafness and education of deaf children to various sections of the community — Youth Clubs,

Young Wives and Mothers Groups, Women's Institutes, Parent Teachers Association, Health Visitors, Nurses, Ladies Circle groups and Soroptimists. As the community becomes more aware of the problems of deafness, it is to be hoped that further efforts will be made to integrate those who are isolated because of hearing impairment.

Mr. Abbot, Teacher of the Deaf in the Western and Southern areas, writes:—

Pre-School Children

Only one new child in this category came under my care during the past year. This little girl had a hearing loss of 45 — 50 db in each ear at all frequencies. However, in November her adenoids were removed and her hearing has since returned to within socially acceptable limits.

One severely deaf child was admitted to a normal hearing school at Easter and is progressing quite well in spite of her handicap. The school concerned has been exceptionally helpful in many ways and I am delighted with the way she has integrated into school life generally. A profoundly deaf boy started at a residential special boarding school also at Easter and he too is now settling down well at school.

Two partially hearing children have both had their conductive losses improved and do not need hearing aids at present. One of these two is now attending a training centre whilst the Department of Audiology at Manchester University feels the second child's trouble to be more of a language disorder than a simple hearing impairment.

Pre-school guidance has been carried out in the home and in all cases where it would benefit an auditory training unit has been loaned

Some fifteen children have been referred for assessment the majority being under five years of age

Profoundly Deaf	1
Severely Deaf	2
Partially Hearing	0
	3

Pupils in Special Schools

Currently there are ten children from South and West Cumberland in residential special schools for the deaf. During the year one boy from the pre-school group started at a Yorkshire Residential School for the deaf.

All of the children were seen at least once during the year. Occasionally children returned home with non-functioning or malfunctioning aids, perhaps this is because these children use a different very high-powered model in the school itself.

Some of the children from the residential schools seemed to have few friends at home and the long holidays could be rather lonely. This is a rather complicated problem and no easy answers were apparent in some cases.

Children with Impaired Hearing in Normal Schools

At present there are forty one children under my care in South and West Cumberland schools. All but two of the children have the O.L.67 post aural Medresco aid, the two exceptions being a child just over five years of age and an older boy who has a bone conduction model. Fortunately the boy with the bone conduction model has not needed to wear it for over a year now as his middle ear condition has cleared up to a great extent. Four children with impaired hearing have left school and found employment, two more have left Cumberland and one boy is now out of my care.

Aids have been withdrawn in two cases and there are two, possibly three more, who could well have the aids withdrawn in the future.

Nine school children have been provided with aids during 1970 — one child at Secondary School, two at Junior School and six at Infant School — most of these losses being discovered through the screening tests carried out at school.

Hearing Aids

Two of the pre-school children have had the Medresco O.L.63 aid in use for a fair period and it appears to have more useable power than the older O.L.56/57 models of body worn aid. I feel it is a pity that a circuit for use with an induction loop was not fitted, obviously this would have been useful in the home, apart from the obvious advantages in schools and units.

The O.L.67 post aural aid has turned out to be a good instrument ind difficulties and breakages have caused very little concern.

One very young child has had to manage with a bone conduction aid, very much a second best method of transmitting amplified sound, but at present it looks as though he will be able to use an air conduction aid after a very delicate operation by the E.N.T. surgeon.

It is still felt that provision of spares for the post aural model to the peripatetic service would be of considerable benefit to all concerned but after several requests some difficulty in supply is still apparent at this date.

Hearing losses on the main speech frequencies for children in schools.

SOUTH AND WEST CUMBERLAND

Up to 30 db	12
30 db to 40 db	10
40 db to 50 db	12
50 db to 60 db	4
60 + db	3
	41

TABLE I
ENTRANTS GROUPS

Area	1966	1965	1964	1963	Total	No. with apparent loss	No. of re-tests	No. requiring investigation
North ..	10	1085	139	48	1282	260 (20.3%)	272	156 (12.2%)
West ...	111	1105	149	4	1369	100 (7.3%)	113	60 (4.4%)
South ...		1010	214	21	1245	191 (15.3%)	163	62 (4.9%)

TABLE II
SPECIAL CASES REFERRED

Referred for testing by:	North	West	South	Totals
School Medical Officer	93	114	61	268
Family Doctor	3	3	27	33
Head Teacher	60	6	7	73
Parent	10	—	9	19
Speech Therapist	1	5	61	67
Teacher of the Deaf	3	—	1	4
Paediatrician	—	—	—	—
Referred re 2 H.P. examination	16	65	—	81
Other — Educational Psychologist	—	—	9	9
TOTALS:	186	193	175	554

TABLE III

Disposal of cases Discovered:	Routine			Special			Totals		
	North	West	South	North	West	South	North	West	South
For observation	36	8	27	40	3	7	76	11	34
Referred to School Medical Officer	48	32	35	19	9	43	67	41	78
Referred to General Practitioner	28	6	5	4	9	28	32	15	33
Referred to Otologist	15	14	23	8	1	7	23	15	30
Referred to Teacher of Deaf	9	—	—	3	—	—	12	—	—
Other	20	—	—	20	—	—	40	—	—
No defect	—	—	—	--	171	—	—	171	—
TOTALS:	156	60	90	94	193	85	250	253	175

Ophthalmology

Regular clinics are held in both East and West Cumberland for children requiring the services of ophthalmologists, either in the hospital or in local authority premises. These mainly concern the examination, follow up and treatment of children suspected of defective vision. Many referrals are, of course, from the routine examination of school children's vision. In the treatment of cases of squint the orthoptists collaborate and comments are given below on this service. We were glad to welcome Miss Smith at the end of the year on her completion of training under the County's scholarship scheme for orthoptists. Dr. Ainsworth and Dr. Marks both continue to assist the consultant opthalmologists in West Cumberland in refraction work and Dr. Ainsworth comments on this, as follows:—

"I have in previous years explained how the most helpful liaison with the Ophthalmologist, Dr. Griffith, continues and this year there are only a few points to add.

One can discuss visually handicapped children personally and this is most valuable. The only new development since last year is that I now see newly referred school children, as well as following up old cases, in my weekly refraction clinic. Since Dr. Griffith is carrying on his hospital clinic in the room next door to my clinic I can check any queries with him, and this of course is another advantage of working at the hospital at the same time as the ophthalmologist".

Mrs. Scott, who is concerned with the Orthoptic Service in the Carlisle and Penrith areas, writes as follows:—

In the middle of 1970 Mrs. Payne found it necessary to do part-time work only, so only two clinics per fortnight have been possible at Portland Square instead of three. It was found necessary to cope with this situation in three ways:—

1. Some patients were transferred to other clinics in the area i.e. Penrith and the Cumberland Infirmary.

2 Some patients who attended for three or six monthly checkings have been discharged and are to see the surgeon only to be referred back if found necessary.

3. Other patients were slowly incorporated into the remaining once weekly clinic as spaces occurred owing to 1 and 2.

It is satisfying to note the number of patients discharged as cured. This is quite a high standard to obtain and demands that the patient should have Binocular Single Vision at all times with glasses and to be able to maintain Binocular Single Vision without glasses with little or no effort, although of course this does not mean that vision will be good without glasses or that reading will be possible without them. This all depends on the refractive error which no treatment will change.

To discharge a patient as improved means that the condition is satisfactory but that the high standard of 'cured' has not been reached. The patient may still squint when reading or have started treatment too late for any Amblyopia ("lazy eye") to have been completely cured — this is known as Intractable Amblyopia.

A cosmetic result is obtained where no Binocular vision is present but the squint is not now noticeable owing to operative treetment. No child is discharged with an obvious squint unless the parents have refused either orthoptic or operative treatment. The following figures give details of cases seen during 1970 and those discharged.

The numbers of children tested in 1970 and the numbers referred for treatment or observation are shown below along with figures for the previous four years.

Year	*Total No. tested*	*Referred for treatment*	*Referred for observation*
1970	14,297	339	1,363
1969	12,303	378	1,495
1968	10,064	310	1,197
1967	11,084	444	1,865
1966	12,085	452	2,028

Details of cases treated during the year are given below:-

Total number of attendances in 1970	1,968
Number of new cases seen	243
Number of new cases registered for treatment ...	223
Number of cases receiving treatment on 31st December, 1970	736

Treatment during year of new cases:-

Partially accommodative squint	63
Fully accommodative squint	19
Accommodative convergence excess	12
Non-accommodative convergent squint	24
Convergent squint with amblyopia	5
Convergent squint with hyperthopia	1
Convergent squint with eccentric fixation	3
Fully accommodative with amblyopia	2
Residual convergent squint	3
Constant divergent squint	4
Divergence excess	5
Divergent squint with amblyopia	1
Mixed type	3
Convergence weakness	1
Intermittent convergent squint	6
Consecutive divergence	3
Intermittent convergent squint	1
Exophoria	1
Exophoria of convergence weakness type	1
Exophoria with defect of accommodation	1
Convergence deficiency	4
Fixation disparity	1
Overaction of inferior oblique	2
Ocular muscle palsy	14
Pseudostrabismus	23
Eccentric fixation	8
Anisometropic amblyopia	12
Total	223

Discharges during the year:-

Cured	28
Cosmetic	10
Improved	12
Failed to attend	7
Left district	7
Not responding	2
Refused	2
Transferred	13
Total	81

Orthopaedic Service.

Much of the orthopaedic care of school children is the responsibility of the hospitals. However, there is still a demand for care outside of hospital and in this respect I am grateful for the services of two part-time physiotherapists in the county

To meet a growing need both in hospital and outside for an extension of the service, a scholarship scheme has been devised in co-operation with the West Cumberland Hospital to encourage suitable candidates to return to work in Cumberland within a joint appointment. I trust this will provide a more adequate and stable service in the near future.

With regard to the past year, I am indebted to Mrs. P. P. Bratt, part-time physiotherapist, in Seascale Medical Centre, for the following report.

> "I have dealt with only a few children at Seascale Centre during 1970. Of the two spastic boys whom I have visited at their homes since 1968, Eric Cook moved on to the Hensingham Day Centre and thence to Irton Hall School last year, and David Hodgson is still visited at Bootle once a week.
>
> There is now a child of 18 months who needs supervision of his mild hemiplegia as he learns to walk. Otherwise last year there have been two patients to be taught flat foot exercises, and the two school children who were referred from the West Cumberland Hospital for courses of short wave diathermy. As they lived in Seascale I was able to treat them at 4-00 p.m. so that they did not miss any schooling".

Speech Therapy

Unlike the orthopaedic service the majority of school children requiring the skills and expertise of a speech therapist come through the local authority or general practitioner services and not through the hospitals. It is therefore essential that an adequate service is maintained with patient demand reflected in the staff establishment. To this end the speech therapy scholarship scheme has been established and is helping to provide a stable service despite the tendency for staff to move.

I am grateful to Mrs. Blacklock for the following report of the speech therapy service during the last year.

"The speech therapy service in Cumberland has suffered again this year from unexpected resignations. We lost one full time therapist in the Southern Area and one part-time therapist in the Northern Area. However, a senior post was established and Mrs. Lahiff returning from Newcastle University was appointed as full-time therapist in the Workington Area. This saw the fulfilment of a long felt need for that area which had always previously been understaffed. The appointment of a senior therapist should help to weld the service into a satisfacory whole deploying the staff according to the needs in each locality. To overcome the feeling of isolation frequently experienced by therapists regular meetings have been held throughout the year both with the County Medical Officer and Area Medical Officers and the therapists themselves have invited the Education Psychologists and the teacher of the deaf to informal discussions which proved very helpful. Two therapists attended the College of Speech Therapists Conference held in Manchester. During the year the work has been programmed to include assessment, advice and treatment We are all enjoying more freedom in our individual approach to our work and/or greater contact with colleagues. More work has been done in the rural areas within the school premises and this contact with the teachers is invaluable. The therapists have been invited to talk to various groups of interested people about their work. The number of these occasions has increased and this pleases us to know of other people's interest in our work. This year saw the beginning of an enquiry into the Speech Therapy Services by the Department of Education and Science. The College of Speech Therapists has submitted its evidence and the result of the enquiry should be published within two years.

One of the most frustrating experiences in our work is caused by the parental disinclination to take advantage of treatment offered to some children who have really severe communicaion problems. In rural areas the teachers often do a magnificent job under guidance from the therapist when the number of children in the class allows the teacher to work daily with the speech defective child. But in the industrial more densely populated areas this is impossible. With the introduction of selective school medical examinations these children are constantly being re-referred because their disoder constitutes a severe handicap to their learning ability. Yet infrequent half hourly periods of treatment are just a waste of time. Some counties are transporting these children to a central school or clinic for daily group and individual help

both for the hangers-on with minimal difficulty who need a short period of intensive therapy and the children with severe difficulties who need prolonged daily treatment. Daily treatment has been given latterly to one Workington child, but there is a very real need for this intensive treatment to be more readily available. Staff shortages are likely to remain with us and possibly the time has come for rethinking our approach.

On the lighter side the average age of referral for speech therapy continues to be low and many pre-school children are seen at the request of health visitors, paediatricians and general practitioners. In some instances up to three members of a family are referred in succession, one small boy warned the therapist months ahead that "our Richard will have to come to you because he doesn't talk properly" and the same boy tried hard to get his best friend in for treatment! Interestingly there is no pattern to the severity of defect within these families which seem to have a tendancy for defective speech. The degree of emotional tension caused in the home by speech defective children should never be underestimated. One is frequently being told of instances where the mother and child are reduced to tears by the mothers failure to understand and her child's frustration that such a state exists. Often these things are not found out until the final visit of a child who now speaks fluently and the mother will then tell you much more fully how worried she was before she first came to the clinic. Disturbingly one still hears of mothers refused access to the therapist and told to ignore the defect and the child will grow out of it. This may well be true but few parents who are worried find it easy to ignore the symptom and it needs a great deal of time and expert guidance to help them and the speech therapist is trained to do just that.

A case of interest was an eleven year old girl referred for the first time with a defective sh and ch sound. The parents were not particularly concerned being convinced that she would grow out of her difficulty. The therapist thought this unlikely and told the parents and their daughter so. But the girl insisted that she wanted to be different and at that stage she declined treatment. However, she did agree to come back again after she had settled down in the secondary school. This she did, there had been no improvement in her speech. She readily agreed to attend weekly for treatment. She is proving a most conscientious patient, who works entirely on her own at home, even tape recording

herself and consequently she is making excellent progress. This girl could so easily have been discharged at that initial interview and it is very unlikely that the defective sounds would have corrected themselves".

The following table shows details of cases treated and attendances during the year:—

	Northern Area.	Western Area.	Southern Area.	Total.
On register 1.1.70	127	144	138	422
Admitted	117	105	62	218
Discharged	71	72	50	231
On register 31.12.70 ...	173	177	150	409
Particulars of cases discharged:—				
Normal	36	43	20	99
Improved, unlikely to benefit further	18	13	9	40
Lack of co-operation ...	5	7	14	26
Left school and/or district ...	11	9	7	27
Passed to teacher of deaf ...	1	—	—	1
Total	71	72	50	193
Waiting list	—	6	—	—

Attendances:-

Northern Area:

Abbeytown	5
Allhallows	4
Alston	12
Aspatria	137
Carlisle	289
Holme St. Cuthbert's	35
Nenthead	14
Penrith	540
Rosley	28
West Newton	21
Wiggonby	2
Wigton Junior School	36
Wigton Infants'	68
Wigton	142

Western Area:

Cockermouth	116
Keswick	112
Maryport	220
Workington	799

Southern Area:

Adult Training Centre, Distington	6
Junior Training Centre, Hensingham	93
Millom	221
Whitehaven	947
Total	3,847

CHILD GUIDANCE

No fundamental change has taken place in the Child Guidance Service in 1970 and as the figures on page 50 show the annual volume of cases handled continues at a similar level as in recent years. Undoubtedly the most significant single event for this service in 1970 was the appointment of Dr. Wood as the first Consultant Child Psychiatrist in the Special Area of Cumberland and North Westmorland by the Newcastle Regional Hospital Board. This is in many ways the culmination of the developments in child psychiatry and child guidance in this area whereby the Regional Hospital Board has over the years seconded to the Child Guidance Clinics various consultant psychiatrists who have given wonderful service to Cumbrian children. Dr. Wood now brings a highly specialised training to this field and furnished Cumberland with one of the few specialist child psychiatrists in the Region. His appointment will serve to considerably mitigate the disadvantages of Cumberland's geographical situation vis a vis the Newcastle area which has been the nearest source of special advice for particularly difficult child psychological problems.

The inter-departmental discussions I foreshadowed in last year's report in certain aspects of the future of the Child Guidance Service were postponed when it was known that Dr. Wood had been appointed to take up post on January 18th, 1971. These will now take place early in 1971 in anticipation of the coming into operational existence as such of the new department of Social Services.

It is encouraging to be able to report that an often-discussed development for young psychologically disturbed children in West Cumberland now promises to come to fruition. This consists of a small unit in association with a primary school in the Maryport or Workington area where maladjustment problems can be referred for earlier and deeper analysis and investigation by a small team of experts, doctors, psychologists and teachers. This has been achieved through the Urban Programme whereby a special government grant is made available for such projects in areas of special social need. I believe this represents a new truly preventive element in the work with children psychologically disturbed and one which offers fresh and challenging opportunities to the various professional disciplines which shall work together to make this a success.

Dr. Blair Hood has worked as a key member of the Northern Area Child Guidance team for a number of years, and I am grateful to him for the following penetrating review of certain child guidance activities:—

> "Since the hard facts of child guidance in the county are contained in our statistical tables, I should like to take the opportunity of expressing quite briefly a few personal views on a number of relevant topics which come to mind. One sometimes wonders, for instance, to what extent the title "child guidance clinic" may mislead people who are not working in this particular field. Each word of this title is, in fact, a misnomer. We are, after all, concerned not only with the child, but almost equally with the child's parents and, in fact, with all the people who are intimately connected with his daily life. We ought to speak of family rather than child guidance. Again, the process is not one merely of guidance; before there is guidance, there must be investigation, which may entail a prolonged enquiry into the total life situation of the child himself, as well as a study of the feelings, attitudes and modes of handling the child which one finds to be characteristic of the parents, relatives, friends and teachers. On the thoroughness of this analytic process depends the success of the guidance which is to follow. However, no one would wish to speak of "family investigation" which smacks of the police court, or "family analysis" which is rather cold and scientific, so in the end the word guidance with its warm, human overtones must stay. And finally, the word clinic, signifying a bed, is somewhat out of place, since going to bed is not a usual consequence of child guidance, any more than are most

of the numerous other activities which we associate with the word "clinic". That there are in the medical sense some clinical overtones in child guidance is true, but these we try to keep as inconspicuous as possible. This is not a campaign to throw out the expression "child guidance clinic", but merely a reminder to all concerned that the activity to which the words refer has much greater depths than the words themselves would imply.

One is reminded, for instance, of an activity in the child guidance field which possibly has not been sufficiently stressed in previous reports, namely the work done for emotionally disturbed children within the schools themselves. Perhaps it is not always realised how much the work of the clinic is supplemented and enhanced by the flexibility of teachers to allow an even closer relationship to grow up between the disturbed child and members of the staff than is normally necessary for the average healthy youngster. They are, in fact, prepared to "nurse" a difficult child through a troubled period of his life with care and personal concern.

We had recently, for instance, a young adolescent boy, a school-refusal case, who could only be settled back successfully in school by being allowed to attend school for short sessions of about an hour and a half each morning until he gradually became accustomed to the total school situation again. Step by step, his time in school each day was extended until now, at the moment of writing, he is very nearly a full-time attender with every appearance of being happy and settled in school. He still, of course, has problems, and still is an "at risk" pupil, but because the staff of the school engineered the situation so skilfully, school in itself has now become a platform of security for the boy instead of a source of anxiety. Another case which comes to mind is of a boy who, as the result of a serious accident as well as great problems in the home situation, became the victim of continuing anxieties. These caused him to break down and cry constantly throughout the school day, so much so that his education practically came to a standstill. On these occasions, this boy's condition was far too distressing for him to be allowed to remain in the classroom, and he was encouraged to go to the study of a member of the staff. Here he would sometimes sit quietly by himself until he had recovered, but frequently he would be joined by this teacher who, with patience and understand-

ing, helped him to overcome gradually his anxieties, at least to the extent of being able to cope with most day-to-day situations in school. These, of course, are just fragments in the case histories of the two particular boys, but they illustrate, as do many others, how only with the full co-operation and active involvement of the school can some child guidance cases be tackled with the maximum chance of success.

These observations have drawn our attention to the close link which must be maintained between the child guidance clinic and the child's school. The justification for maintaining this link is based on what I believe to be a more general basic principle of child guidance, namely the maintenance, so far as possible, of normality in the child's total situation. I would concede, of course, that for some disturbed children removal from their own school to attend a special unit on a part-time basis and for a limited time could well be beneficial, and in extreme cases even removal from home to attend a residential establishment might be the only way of helping a severely disturbed child, yet for the majority, home and the neighbourhood school are the natural setting in which children should be helped to work out their difficulties. Furthermore, I would judge that an inspection of child guidance premises throughout the country would show how clearly the effort is made to avoid the cult of abnormality. Usually the premises were formerly a private house, and even where child guidance is carried on in a local authority's public health clinic, the rooms are "furnished" just as much as they are "clinically equipped". There are comfortable chairs, small tables for children, books, pictures, toys and so on. There are no white coats or nurses' uniforms. The child who comes to the clinic does not normally deem himself to be ill, according to the child's usage of that word. Nor, of course, do we wish to let him think that he is ill. To the child, being ill means to feel unwell and unhappy, with a certain resignation that he simply has to lie back and let the doctor make him better. This, of course, is not the attitude which one wishes to foster in child guidance. One wants the child, within the limits of his age, capacities and temperament, to play an active part in coming to terms with his difficulties. We want him to like the place to which his mother has brought him. It must be a place where he can enjoy himself, and which will not cause him any anxieties because it is vast,

clinical, and unknown. And finally, it must also be a place which will reassure the mother in her own concern about her child, so that her niggling worry about the words psychiatrist and psychologist will be played down as she steps with her child across the threshold of the child guidance clinic."

CHILD GUIDANCE CENTRES — STATISTICAL RETURN FOR THE YEAR ENDED 31-12-70

STAFF:	Carlisle:	Maryport:	Workington:	Whitehaven:	Millom:	
Psychiatrist	Dr. J. R. Burgess	Dr. T. Ferguson	Dr. T. Ferguson	Dr. T. Ferguson	Dr. T. Ferguson	
Educational Psychologist	Dr. H. Blair Hood	Mr. K. G. Hare	Mr. K. G. Hare	Mr. M. Ruddick	Mr.J.M.Ruddick	
Psychiatric Social Worker	Mr. I. Moffet	Mr. A. Davidson	Mr. A. Davidson	Mr. S. Butterfield	Mr. S. Butterfield	Total
Cases remaining on register at 1st January, 1970	49	18	109	38	10	224
New cases referred during year by:—						
Consultants of General Practitioners	40	4	4	4	—	52
School Medical Officers	4	5	20	25	3	57
Children's Officers	5	—	—	—	1	6
Parents	—	—	—	—	—	—
Schools	10	—	—	2	5	17
Probation Officers or Courts ...	3	—	—	—	—	3
Others	2	—	1	—	—	3
Cases re-opened during the year ...	1	—	—	3	—	4
Total cases on register during year ...	114	27	134	72	19	366
Cases dealt with and closed	50	2	7	48	15	122
Cases remaining under treatment on 31-12-70	57	25	127	24	4	237
Cases awaiting treatment on 31-12-70 ...	7	—	—	—	—	7
	114	27	134	72	19	366
Interviews by Psychiatrists	234	27	82	104	13	460
Interviews by Social Workers	119	6	24	41	3	193
Interviews by Educational Psychologists	101	37	184	112	18	452

CHILD GUIDANCE REGISTER 1966-1970

		1966	1967	1968	1969	1970
Total new cases during year	East	86	72	70	84	114
	West	519	563	618	208	252
		605	635	688	292	366
Total on Register during year.	East	37	41	39	56	65
	West	58	71	113	76	77
		95	112	152	132	142

HANDICAPPED PUPILS

Continuing developments in this field include forward planning for special primary school building adaptation for severely physically handicapped children. Mention was made last year of fresh assessment of the future needs of children suffering from spina bifida and during 1970 the decision was made to adapt two primary schools each year to accommodate such children providing ramped approaches where necessary and modified and enlarged toilet compartments for them. The particular schools to be chosen each year will be decided upon, on the basis of known children with this handicap coming forward to school entry. The school medical officers have completed a detailed survey of the pre-school children with spina bifida or similar disability to this end. The provision in appropriate schools of special non-teaching staff is a tremendously important advance in the matter of containing severely handicapped children in ordinary schools and it it a matter of regret that financial considerations are retarding the progress of such appointments at present.

I deal below with some of the points arising in connection with planning for April 1st, 1971, when the Junior Training Centres for subnormal children become special schools under the administration of the Director of Education and the Education Committee. This seemed an appropriate moment at which to review screening follow-up procedures for pre-school children likely to be suitable for these special schools in the future. As a result an arrangement has been arrived at for the bringing forward at an early stage (normally at two-years of age) of any child thought to be a possible candidate for such special education. A panel consisting of the Area Medical Officers; the Educational Psychologist, a Social Worker from the Department of Social Services, accompanied by others as occasion demands will meet regularly to review these cases and to agree upon the best approach to assessment at different stages including concerted parent counselling. A major responsibility in this connection for the Area Medical Officer will be careful liaison with other doctors concerned in the case, family doctors and a variety of specialists.

Of immediate relevance to these arrangements is the following penetrating analysis of her work with handicapped and deprived pre-school children, by Dr J. E. Ainsworth, Medical Officer in Department in the Western Area who has become highly expert in the assessment of the develop-

mental problems of the potentially handicapped child. All of this only emphasises further how child health services must be viewed as a unity. What Dr. Ainsworth writes about below is the foundation of the future health of a highly vulnerable group of children with special needs who are soon to come into school.

She writes as follows:—

"Handicapped children include deprived children, because these children can be almost as much handicapped by deprivation as is a child with a physical or mental handicap. The handicapped service involves a wide variety of doctors, e.g., paediatricians, other specialists, family doctors or doctors in Local Authority work, as well as people with special expertise in other disciplines, e.g. educational psychologists, physiotherapists, speech therapists, teachers in various capacities, limb and appliance fitters, children's officers, mental welfare officers, youth employment officers, etc.

The handicapped child starts in some cases to need this service from birth and this may be needed to continue throughout a handicapped person's life, and these doctors and others, with expertise each in their own fields, all try to work as parts of a huge jigsaw to help the handicapped individual.

There are two aspects in the care of children which will, from now on, play increasingly large parts — these are:—

1. the promotion of health — physical, mental and social — and
2. the care of children with chronic handicaps.

I can only talk here about my work as I see it now and as it involves me with the handicapped; and possibly how the future could evolve so that a useful service could be given to the Handicapped and Deprived. Of course, my work is only a facet in this much larger group of people who are involved.

My special interests are in child development and its allied problems, both in the pre-school child from birth to 5 years, in the child at our Infant schools, and in giving consideration to older school children with handicaps, whether these are physical, mental or social. This is so that with the school children educational requirements are made

and offered, even on to trying to help the youth employment officers with finding suitable occupations for those with handicaps.

In the pre-school child developmental screening examinations and assessments of difficult cases are being carried out in the Workington area, and through these specialised examinations early developmental delay can be recognised. If delay is recognised, it becomes possible by further examination to identify the underlying handicap or handicaps, and this includes social deprivation as this can cause developmental delay.

If children with handicaps are to be identified early, then *all* infants and children, some people believe, should have a series of periodic developmental screening examinations. When there is reason to suspect that a child has, in any way, delayed development, then this child is referred to an expert, such as the paediatrician, for further assessment and treatment, and for guidance of the parents.

Children with chronic handicaps, e.g. of lungs, heart, metabolic or of cerebral origin, usually have multiple rather than single handicaps. Handicaps, and especially those of cerebral origin, lead to delay in development. These chronic handicaps are often present from early life, and secondary complications — medical, educational and social — frequently occur. These can be prevented only if comprehensive management of the child and its family are started early enough, hence early identification is therefore essential.

In planning these developmental screening examinations to pick up as early as possible children with delayed development, the child's function is considered in four main areas:—

1. Locomotion and Posture.
2. Vision and Fine Manipulation.
3. Hearing, Language and Speech Development.
4. Everyday Skills and Social Development (including emotional relationships).

These screening examinations are carried out at special key ages because certain levels of development are known to be recognisable around these ages. These key ages are:—

6 weeks; 6 months; 10-12 months; 18 months; 2 years; 3 years; and 4 years.

In the Workington area we are carrying out these developmental examinations in the Child Health Clinics previously known as Child Welfare Clinics, and mothers are encouraged to bring their pre-school children by appointment for their special developmental screening examinations. By introducing an appointment system it has given time to each child for this examination to be adequately carried out. At Salterbeck Clinic I have recently started extra developmental clinics by appointment, having six additional sessions each month to try to screen as many children as possible. The majority are screened only at 6 weeks, 6 months, 10-12 months, 2 years. 3 years and 4 years, and are only seen otherwise if there is any concern or query.

I would hope or suggest, and would like to see, that as the future develops in a reconstructed National Health Service, it would be of much value to be able to develop an attachment to a group of family doctors to help to developmentally screen their pre-school children. This would be a move forward to the early discovery of handicaps and also greater co-operation would develop with the family doctor. This principle of attachment of nursing staff, i.e. district nurses, domiciliary midwives and health visitors, to groups of family doctors is already of value and well established and this could be a further useful extension of this. This, of course, would need a full understanding and appreciation of the role each has to play in relation to his or her particular interest and experience and would need true professional co-operation. In this way full use could be made of the limited resources of medical manpower available in this country, and at the same time providing the best possible service.

As well as looking for handicaps early in the pre-school child we are also working out a new comprehensive specialised type of neuro-developmental entrant examination of school entrants, again to help to discover children soon after school entry with minor neuro-developmental disorders which handicap these children educationally or behaviourwise. These are the children in the past who have been presented to us at 8, 9 and 10 years of age with behaviour disturbances in school or learning disorders, related to something wrong with development or maybe with brain function. It is at present believed that 5% of children at school entry have some type of these less obvious disorders. These children are often seriously handicapped at school, and it is by recognition of these children early that understanding,

tolerance and help can be given rather than the child being misunderstood so that the handicap could eventually produce secondary handicaps, e.g. of behaviour, etc. In this 5% the handicaps include disorders of body-image, specific learning difficulties, mental retardation and disturbance of behaviour. It is recognised that children with neuro-developmental disorders are four to five times more at risk than normals to develop behaviour difficulties. In the Rhode Island studies it was found that all children who failed the first grade were those detected by developmental neurological tests, and they had either learning or behaviour problems. We hope that by introducing this examination in Infant schools that we will be able to point out to the teacher an affected child's assets and difficulties and so help a child's development rather than aggravate its difficulties.

In addition, my work involves me very much with handicapped school children — that is with children at school with social, mental and physical handicaps — and here one is concerned with helping these children to derive the greatest benefit from their education, whether it be to recommend special education in a special school or unit, help by the Child Guidance Service or advising for special provisions to be made in normal school. We do try if possible to integrate as many children as is possible with handicaps in a normal school environment, but there are those in which the handicap is so severe that this is not possible as the child's learning would suffer as a result and then some other provision has to be considered. This work covers a very wide field, and ranges from purely medical disorders, e.g., diabetes, haemophilia, epilepsy, to mental and emotional handicaps and to hearing, visual and locomotor handicaps.

I have an attachment to the opthalmology clinic at Workington Infirmary, and this is a most valuable hospital link, as it gives an opportunity to discuss visually handicapped children one deals with, with the opthalmologist and this is a further useful liaison in working with the handicapped.

Possibly by developing the service to children who are handicapped or/and deprived in these directions in the future this will help to bring out their full potential and to try to avoid them getting into situations where their handicap can cause feelings of failure, so leading to secondary handicaps which can be in the form of behaviour difficulties.

Writing on the now well established handicapped school leavers conferences, Dr. Bentley, Northern Area Medical Officer, comments:—

"This Conference was attended by school medical officers and school health clerical staff from the area office, together with the senior social welfare officer, the teacher of the deaf, the youth employment officer and the educational psychologist. The underlying difficulties were those of finding employment in areas where there is not much employment available even for normal school leavers. Another problem is that of finding employment for educationally sub-normal children who have remained at ordinary schools and who are leaving at 15 years of age.

A major problem has been encountered in trying to place a special school leaving girl who suffers from multiple handicaps. She is educationally sub-normal and has poor vision and wears a hearing aid. Unfortunately she also has a very shy personality. Her mother was infected with Rubella during the second month of her pregnancy and all these physical defects are the result of Rubella infection."

From the Southern Area, Dr. Marks illustrates in her comments below some of the benefits of these conferences:—

"The handicapped school leaver has always presented a problem especially in this area of high unemployment figures, but with the development of the new industrial sites, providing mainly light industries for West Cumberland, we hope there will be a wider choice of work to suit the capabilities of this group of young adults. The youth employment service do play a very great part in advising the school leavers of suitable available employment; they liaise between employer and suitable employee and provide a continuity of supervision and counselling.

The twice-yearly conference attended by the Youth Employment Officers, Area Medical Officer, School Medical Officers, Social Welfare Officers, Educational Psychologist and the Consultant Paediatrician is valuable in so far as it summarises the child's mental and physical capabilities to date, and they are made aware of the choice of career by parent and child.

As the field of employment is limited there has often been difficulties in offering a post of their choice to the handicapped school leaver, but they are advised on the type

of work which is suitable for their disability. The asthmatic is advised to seek employment which does not involve working in a damp, dusty atmosphere, the epileptic to avoid working at heights or near moving machinery and to confide in a tolerant, sympathetic employer. The child with a locomotor disability may find a sitting down post the most suitable type of occupation. Take the case of one such pupil. She was a cerebral palsied girl with spasticity of the lower limbs and ataxic gait. The Youth Employment Officer had a summary of her physical and educational abilities, her wishes on the type of work she would like, her desire to be working in the same environment as her friends, and was able to suggest employment in a factory for mainly female labour as a telephone operator. This type of work was found and the girl has happily settled at the factory. The prospects for the spastic child of today are very much better than what the average adult spastic is doing now.

On reaching school leaving age the handicapped young person may register as a disabled person under the Disabled Persons (Employment) Act of 1944. A person is eligible for registration if on account of injury, disease or congenital deformity he is substantially handicapped in obtaining or keeping employment or in undertaking work on his own account.

Registration offers one benefit. Every employer with more than 20 employees is obliged to employ a certain percentage of registered disabled people, therefore a handicapped person who is registered has a greater chance of entering normal industrial employment than one who is not. Also many companies which operate pension and similar welfare schemes and require that all entrants to their employment shall be physically sound are prepared to relax that requirement in favour of a registered disabled person.

These conferences which are held at least nine months before the child leaves school, do form a useful link between the school health service and the youth employment department, and their usefulness will be of even greater value when the demand increases for employees which we hope will be in the near future because of the new industries coming to the area."

HANDICAPPED LEAVERS' CONFERENCES

Cases considered were as follows:—

Deaf and partially hearing	10
Blind and partially sighted	5
Epileptic	5
Diabetic	4
Physically handicapped	55
Educationally Subnormal	72
	151

CHILDREN SUFFERING FROM CEREBRAL PALSY

The numbers in this category at 31st December, 1970, are as follows:—

Numbers of spastic children of school age—

North Cumberland	17
South Cumberland	29
West Cumberland	17
	63

These may be divided into those:—

(a)	Attending ordinary school	45
(b)	Attending Percy Hedley School for Spastics, Newcastle	2
(c)	At Residential Schools for the Physically Handicapped	—
(d)	At Residential Schools for the Educationally Subnormal	—
(e)	Attending Training Centre	10
(f)	At Dovenby Hospital	2
(g)	At Prudhoe Hospital	—
(h)	Having Home Tuition	—
(i)	Not attending school, not having home tuition	2
(j)	Irton Hall	1
(k)	Special Care Unit	1
		63

In addition:—

Number of children under school age but within the scope of the Education Act (i.e., 2-5 years) who are known spastics:—

North Cumberland	2
South Cumberland	7
West Cumberland	—
	9

Table showing Handicapped Pupils in Special Schools

	Boys	Girls
1. Physically Handicapped		
Irton Hall, Holmrook, Cumberland ...	7	—
Percy Hedley School, Newcastle-upon-Tyne ...	1	1
Lord Mayor Treloar, Froyle, Alton, Hants.	1	—
H. K. Campbell School, Carlisle ...	1	—
Moss Brook School, Norton, Sheffield	1	—
	11	1
2. Deaf		
Royal Cross School, Preston ...	1	5
Northern Counties School, Newcastle-upon-Tyne	6	1
St. John's School, Boston Spa, Yorkshire	—	1
	7	7
3. Partially Hearing		
Royal Cross School, Preston ...	—	1
Northern Counties School, Newcastle-upon-Tyne	1	—
School for Partially Hearing, Birkdale, Southport	2	1
St. John's School, Boston Spa, Yorkshire	1	—
Bridge House School, Yorkshire ..	1	—
	5	2

4. **Blind**

Royal Normal College, Shrewsbury ...	2	—
Henshaw's Institution for the Blind, Manchester	1	—
Chorley Wood College, Hertfordshire	—	1
Worcester College for the Blnd, Worcester	1	—
	4	1

5. **Partially Sighted**

Royal Normal College, Shrewsbury	—	1
Derby School for partially sighted, Fulwood, Preston	—	2
St. Vincent's School for Blind and Partially Sighted, Liverpool ...	—	1
	0	4

6. **Maladjusted**

Camphill Rudolf Steiner Schools, Bieldside, Aberdeen	—	1
Adlestrop Park, Nr. Moreton-in-Marsh, Gloucestershire	1	—
(Boarding Hostel only—pupils attend ordinary schools)	1	1

7. **Educationally Sub-Normal**

Higham School, Bassenthwaite Lake, Cumberland	—	35
Ingwell School, Moor Row, Cumberland	61	—
Allerton Priory R.C Special School, Woolton, Liverpool	—	1
	61	36

Educationally Sub-normal Pupils

This group of handicapped children, the largest single group, has never been a very accurately-defined one mainly because of the scatter of children over the wide spectrum of

ability. Those children thought to require special examination in this regard and "ascertained" by a school medical officer, in conjunction with the Educational Psychologist, have constituted the "official" list of E.S.N. children. The level of referral by head teachers has, of course, varied greatly between schools and at different periods of time. Really specialised help was virtually confined to the secondary school level until recently and the two E.S.N. units attached to junior-schools in West Cumberland have demonstrated their great usefulness since their establishment. I am grateful to Mr Burns, Headmaster of Ashfield Junior School, Workington, for an account given below of the work of the unit in his school under the care of Mr. Winter. The possible place for similar units for day attendance at the secondary stage seems to merit careful evaluation especially in view of the substantial number of E.S.N. children considered for admission to the residential E.S.N. schools and whose parents refuse to allow them to go there. It does seem clear that special day units have a great deal more to offer than the 'progress class' which, with its limitations, has been expected to fill this bill hitherto.

Mr. Burns' report from Ashfield School follows:—

"It was decided shortly after the Unit opened in the summer term of 1969, to change its title from Progress Unit to Special Education Unit, as this more aptly describes the type of children catered for here.

The children attending the Unit are readily accepted by those from the main school who mix with them naturally in and out of the Unit. Where ever possible they are given the opportunity to compete on equal terms with children of their own age.

Frequently new children tend to remain within the sheltered environs of the Unit, but as their confidence increases they seem to want to explore their surroundings and join the other children at play. Some children adjust very quickly, others take longer and one or two prefer to spend most of their time in the Unit.

Our visits to Moorclose Baths still remain the highlight of the week, and although we have not many swimmers their their knowledge and confidence in water has improved beyond measure.

The work in the Unit is done informally, each child being catered for according to his or her individual needs. It is an "open plan" Unit and the children are allowed to move about and choose their own working areas. For part of the day they are free to choose their own working areas. For part of the day they are free to choose their own activities, which may range from extra maths to wood-work The children share the attention of Mrs. Dawson and myself, and although their ages vary from 7 years to 11 years we work as one group. The older children frequently play with the younger ones and cheerfully help them, dressing and tying shoes. Our planned stay at Hawse End outdoor pursuits Centre will be an extension of our school activities both social and academic.

Our work with these children is strongly supported by the school health service, and Mrs. Lahiff, our Speech Therapist, who works regularly in the Unit.

Working closely with Mr. Hare the Educational Psychologist, we try to build up an overall picture of each child so that we can assess their more urgent needs and plan our work accordingly, though this is sometimes hampered by lack of written records".

Mr Burns and all the teaching staff at Ashfield are most co-operative and helpful. It is their attitude which makes the treating of handicapped children within a normal school so smooth and relatively trouble free.

And from Hensingham Junior School Mr. Gauld reports:

"The number of children on roll at the Special Education Unit at Hensingham Junior School is twenty-eight. Children are admitted via the educational psychologist from schools in Whitehaven and its environs. The children who come to us are mainly those whose backwardness is due to limited ability and whose all round retardation would seem to require a long period of specialised treatment. We do also have two of three children who are in attendance because of severe reading difficulties. Many of the children when referred to us by the educational psychologist are described as showing various degrees of maladjustment

There are two classes of fourteen children each. In addition the Unit operates, with the co-operation and participation of the headmistress and staff of the parent school, a further service that aims at giving support to failing children in the parent school. These children are tested, their

difficulties are diagnosed and work is prescribed for them They usually need a good deal of individual attention and the Unit is able to share this work with the child's teacher. The educational psychologist gives us his valuable support in this project and can be called upon when the severity of the case merits his expertise. We also call upon the many other departments of the School Health Service and our calls for help are invariably answered with gratifying promptness and efficiency. Only the shortage of speech therapists give us cause for concern as so many of our children are in need of this important service.

A significant event which is shortly to take place and which is giving food for thought is the implementation of the Education (Handicapped Pupils) Act 1970 which comes into force on April 1st, 1971. On this date responsibility for the education of the children at present in Training Centres will be assumed by the Department of Education and Science".

2 H.P. Examinations completed in 1970 under Section 34 or 57

Recommended Special School—E.S.N.	68
Recommended Special Class—E.S.N.	25
Reported unsuitable for education at school ...	21
No special educational treatment required	8
Decision deferred	10
Recommended admission to school for maladjusted	1
	133
Number of boys on waiting list for Ingwell School ...	51
Number of girls on waiting list for Higham School ...	27

NEW CASES REFERRED IN 1970

Placed under supervision for further investigation of intellectual capacity	69
Referred by:—	
School Medical Officers	25
Psychologists and Teachers	38
Consultants and Hospitals	4
Health Visitors	—
Others	2
	69

Supervision of Educationally Subnormal School Leavers

	1968	1969	1970
Total number of leavers	40	52	69
Placed under supervision of Social Welfare Officers	11	13	27
How placed at end of one year:			
(a) employed	7 (6)	8 (8)	14
(b) unemployed	2 (2)	2 (1)	6
(c) unemployable	1 (2)	—	1
(d) at training centre	1 (1)	3 (3)	6
Placed under supervision of Health Visitors	33	17	23
How placed at end of one year:			
(a) employed	28 (26)	15 (15)	20
(b) unemployed	5 (4)	1 (1)	2
(c) unemployable	— (1)	1 (1)	1
(d) at training centre	—	—	—

Figures in brackets denote the situation at the end of 1970, of 1968 and 1969 leavers.

DENTAL SERVICE

Cumberland is now well staffed and it should be possible to offer a complete service to all who accept treatment by the County dental officers. There are nine full time dental officers and one auxiliary. Statistics relating to the dental service can be found on page 92.

The majority of clinics are well equipped with the most modern equipment, so that the operator may sit to work if he so wishes. The authority is doing its utmost, considering the current financial position, to bring all up to date and to provide X-ray facilities in each area.

It is disturbing to find that so many schools still have tuck shops and that those which have sell mainly cariogenic foods and sweets. One realises that tuck shops are a good source of revenue, but in educational establishments surely it would be better to sell only nuts, crisps and fresh or dried fruit, thus hoping to establish sound eating habits in the young.

Fillings are now far more readily accepted by the patients and one is conscious of an improvement in the standard of oral hygiene in very many cases. Most older children are more dentally conscious now and many requests for treatment are received from the children themselves.

Especial praise should be accorded to the staff at Whitehaven Grammar School for all their co-operation over the dental surgery, but in particular to the Matron, who makes sure that appointments are kept and who has done more than anyone else to promote good oral hygiene and to make children realise the value of dental care.

The supply of X-ray apparatus is still inadequate for present needs, but it is hoped to remedy this next year, and also to bring other surgeries up to a suitable standard to enable operators to work in greater comfort using modern techniques.

A new dental clinic is to be started at Keswick Cottage Hospital to replace the obsolete and most unsatisfactory one. This clinic in the hospital will be very modernly equipped and the accommodation provides all facilities in a convenient manner. One is pleased to see more and more integration of services and this is certainly a progressive step.

PREVENTION OF INFECTION

The start of the year saw the resumption of the measles vaccination programme Supplies of vaccine became available once again in March but the response by the parents of unprotected children was not very encouraging despite publicity in the Press and on television. During the year, 3,245 children between the ages of 1 and 15 were protected.

There obviously lingers in many people's minds some reservations about measles vaccination. This is most unfortunate since the safety and advantages of the procedure are thoroughly established. It will be a great pity if substantial numbers of children must acquire their immunity to this often disabling disease by the process of suffering an attack with all the attendant risks Fortunately measles protection is included in the schedule of immunisation procedures and in the computer call-up arrangements and early indications are that this will result in fewer children missing this protection by default of parental initiative based on outdated suspicions of the procedure.

During the later part of 1970 a recommended vaccine against Rubella (German Measles) began to become available but very limited supplies were obtainable before the beginning of 1971. Plans were, however, laid for the protection of all thirteen year old girls at school early in 1971 and at the time of writing this report this exercise is nearing completion. Although it is not yet clear just how long this immunity will last it is anticipated that girls of this age will carry their protection well into their later child bearing years. Any need for reinforcement later will become apparent from on-going research and can be dealt with as required. In due course both older and younger girls will be able to receive rubella vaccine and ultimately it will find a place in the schedule operating through the computer scheme.

The latter scheme is well under way in the county. By the end of 1970 the entire county was covered for the call-up of all young children for their primary protection against diphtheria, tetanus, whooping cough, polio, measles and smallpox. It will be realised, however, that this does not yet affect school children who for the next three years will still require their main reinforcements (against diphtheria and tetanus and polio) soon after school entry. It is of the utmost importance that parents ensure that their five year old children do not miss this necessary reinforcement and I comment below on the numbers covered at this stage. The

recent re-appearance of diphtheria in the Manchester and London areas should serve as a warning that unprotected or incompletely protected children are still at grave hazard should this deadly infection be reintroduced.

The numbers of school children protected against diphtheria and tetanus in 1970 were as follows:—

Diphtheria:	
Primary Course	353 (460)
Reinforcing injections	2763 (3760)
Tetanus:	
Primary Course	372 (507)
Reinforcing injections	3863 (3950)

(The figures in brackets refer to the previous year).

The reduction in the figures from 1969 for diphtheria is accounted for by the fact that the currect schedule of vaccinations and immunisations no longer provides for a reinforcement dose at ten years of age. In fact the numbers of children "topped up" (i.e. either reinforced or given primary protection after having missed this in earlier life) at school entry stage has remained very constant over recent years at approximately 2,800. This results in approximately 80% of children at this stage being fully protected — a figure about which we should not be complacent in view of the ever present hazards I have mentioned above.

Once again B.C.G. vaccination against tuberculosis was offered during the year to 12-13 year old children, 2,988 children received a preliminary skin test and of these 153 i.e. 5.1% were found positive. The remainder who represent the majority susceptible to tuberculosis infection were offered B.C.G. vaccination, a total of 2,755 being in fact so protected. 232 children had already had B.C.G. vaccination for some reason and 16 were already under the care of the chest clinic

A total of 3,962 children were protected against polio in 1970. Of this number 401 were primary vaccinations and the remainder reinforcements.

INFECTIOUS DISEASES

The table showing the number of cases of infectious diseases in school children is on page 70. Once again this year attention focuses on measles and infective

jaundice. The numbers of cases of the former among school children were very high and disappointing in relation to the measles protection campaign. However, there is no doubt that to some extent at least this rise in instances of the disease is associated with an unfortunate break in the suuply of measles vaccine and the consequence set-back in the protection campaign. This difficulty is now removed and at the time of writing this report it has been confirmed that reassuring numbers of young children are being protected as part of the computer call up for vaccinations and immunisations and fresh attempts will be made as from September this year to cover all children entering school who have not either been exposed to measles or protected against it before school entry stage.

The figures for infective jaundice are again rather higher than last year. In this disease of complex epidemiology attention must be concentrated on scrupulous personal and food hygiene in attempting to prevent spread of the disease which tends to accur in pockets in particular geographical situations, in 1970, notably the Millom and Wigton areas of Cumberland. In the previous year the Penrith area of the county was the most markedly affected. All the health workers in these areas are alerted to opportunities for particularly concentrated health education in the presence of this condition.

CASES OF INFECTIOUS DISEASES IN CHILDREN OF SCHOOL AGE, 1970

	Scarlet Fever	Whooping Cough	Measles	Dysentery	Meningococcal Infection	Encephalitis	Ac. Pneumonia	Food Poisoning	T.B. Respiratory	T.B Meninges and C.N.S.	T.B. Other	Paratyphoid	Infective Jaundice	Puerperal Sepsis	Erysipelas	TOTAL
URBAN DISTRICTS:																
Cockermouth ..	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Keswick ...	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	1
Maryport ...	6	6	240	—	—	—	—	—	1	—	—	—	6	—	—	259
Penrith	6	2	181	1	—	—	—	1	—	—	—	—	6	—	—	197
Whitehaven ...	2	1	492	—	—	—	—	—	—	—	—	—	—	—	—	495
Workington ...	8	1	112	—	—	1	—	—	1	—	—	—	2	—	—	125
RURAL DISTRICTS:																
Alston ...	—	—	3	—	—	—	—	—	—	—	—	—	—	—	—	3
Border ...	—	—	56	—	—	—	—	—	—	—	—	—	3	—	—	59
Cockermouth ...	3	—	117	—	—	—	—	—	—	—	—	—	3	—	—	123
Ennerdale ...	—	—	305	—	—	—	—	—	—	—	—	—	1	—	—	306
Millom ...	1	—	203	6	—	—	—	—	—	—	—	—	49	—	—	259
Penrith ...	9	—	43	—	—	—	—	—	—	—	—	—	2	—	—	54
Wigton ...	13	8	210	—	—	—	—	—	1	—	—	—	41	1	1	275
TOTAL ...	48	18	1,962	7	—	1	—	1	3	—	—	—	114	1	1	2,156

Swimming Baths

The Southern Area Medical Officer reports as follows:-

"During 1970 Millom School swimming pool was out of commission part of the year due to failure in the chlorinator, heating and lining of the pool. The necessary remedial work has now been carried out. Two water samples taken from this pool were satisfactory. Seascale School pool had less use than in previous years and was closed during the holiday periods. One water sample was taken and found to be satisfactory.

Two school baths, Wyndham and Ehenside Schools, were inspected on average at fortnightly intervals and found to be satisfactory.

Overend School bath was opened approximately three years ago and serves the pupils of Overend and Whitehaven Grammar Schools, and the Junior Training Centre for mentally handicapped children at Hensingham. The bath is 20m. long and adapted for both teaching and competitive swimming. An inspection is made once a month and a water sample taken. All results have been satisfactory."

The Northern Area Medical Officer also reports:—

"School children in the Brampton area use an open air pool at Irthing Valley School, Brampton. Schools in the vicinity of Wigton use the public baths in the town. Schools in Lazonby and Penrith use baths operated by a voluntary association at Lazonby. Learner pools are used at one school in Penrith and also at Alston and Houghton. During the year there have been no hygiene problems in any of these swimming pools."

HEALTH EDUCATION AND THE WORK OF THE SCHOOL NURSE

There has been little change in the work of the school nurse in 1970. As in previous years much of the "routine" work such as vision testing and attendance at school medical examinations has been done by specially appointed school nurses, all of whom were qualified. The health visitors, however, retain the responsibility for the overall nursing care of "their" schools, and are always available to help both teaching staff and parents with any problems arising.

Study days have been arranged during the year for both health visitors and school nurses. Various topics have been discussed, among them the growing problem of obesity in schoolchildren. There have also been lectures and study days on the art of Public Speaking -- necessary for nursing staff who are asked to give specialist lectures in schools.

Rather less Health Education has been done in schools this year than in previous years. This is partly due to the fact that topics previously considered to be the province of the health visitor now from part of the normal curriculum and are therefore covered by the teacher. Also a considerable amount of counselling and leading of discussion groups in schools is now done by Marriage Guidance Counsellors who are specially trained for this work. Health visitors find that the time they have available for school work is limited, but are frequently asked to come into schools as teachers, or as examiners, for certain specialist topics. Medical officers are also involved in School Health Education in varying degrees.

The school nurses' personal contact with the children during hygiene and medical inspections gives some opportunity for individual and small group instruction, although this tends to be mostly on the subject of personal hygiene.

Subjects taught in the schools by Health Department staff have been varied and topical. As well as the more usual Hygiene/Mothercraft/Child Care subjects, lectures have been given on such topics as weight reduction, drugs, alcohol and smoking and pollution. Children have also been prepared for the National Association of Maternal and Child Welfare Course and for the Duke of Edinburgh Award Scheme. In all, 169 sessions were given by county nursing and medical staff, involving 5,499 children.

Dr. Bentley reports from Northern Area:—

Health visitors have carried out the bulk of the formal Health Education in talks and discussions during the year and have covered a wide variety of topics. Talks on drug addiction and venereal diseases have been given in some secondary schools by School Medical Officers. An attempt is being made to work out a simple but comprehensive pro-programme of talks involving and co-ordinating the Medical Officer and the health visitor to assist teachers where they feel the need for special knowledge and medical support. Several Head Teachers have been advised on health education booklets suitable for staff or pupils. Many useful and inexpensive booklets produced by the National Association for Mental Health and Family Doctor publications are not well known to teaching staff and are useful additions to either the staff library or the general school libraries used by pupils.

And Dr. McMillan, from the Southern Area:—

"I have had the opportunity of giving several educational lectures to senior pupils. These have included talks on smoking, drugs, venereal disease and normal pregnancy and childbirth, conjunctional with educational films or television programmes and I feel it is a useful part of the work of a School Medical Officer. I have also lectured twice to groups of children with regard to their human biology syllabus which includes many aspects of the Public Health Service."

The Western Area Nursing Officer, Miss Crossfield, writes as follows on the activities in that Area:—

"1970 was a difficult year for the school nurses as three of the four commenced duties during the year with no previous experience of this type of work, and thus for part of the time we were understaffed.

The nurses undertake the routine work of school medical examinations, hygiene inspections, B.C.G. and Rubella vaccination, vision testing, and attendance at the eye clinics at Workington Infirmary and Cockermouth Clinic.

Mrs. Frain at Cockermouth also visits Highham School weekly to attend to any minor ailments among the girls and to assist with matters of personal hygiene. She has a good relationship with the headmistress and visits the girls' homes as required to follow up matters arising at school.

Maryport has been particularly busy this year with an increased incidence of scabies, during which the school nurses and health visitor worked together.

Mrs. Carrick at Maryport has also given considerable assistance to the health visitor by attending at immunisation clinics and undertaking some of the 5 year old pre-school visits. This has been very useful in this area where we are so short of health visitors.

All the nurses help and encourage the poorer type of family by arranging holidays for children, clothes from W.R.V.S., trying to improve home conditions, and in cases of maternal illness requesting home helps. This is undertaken with full consultation and co-operation of the health visitors and general practitioners.

Senior Schools

Mrs. Hewitson, health visitor, runs courses for girls at Salterbeck and Newlands Schools in Workington and at Netherhall School in Maryport.

Miss Dixon, health visitor, has two courses for girls at Derwent School in Cockermouth.

The health visitors in Keswick do not undertake courses, but on request from the schools give specific talks to senior girls.

Junior and Infant Schools

School nurses give short talks on specific subjects, e.g. smoking, dental hygiene, but due to the staff changes this year have not been able to do as much of this as they normally do.

All the nurses keep in close touch with their schools, visiting frequently, apart from undertaking specific work in these schools, to discuss particular children such as handicapped pupils and those with poor home conditions or frequent sickness.

The school nurses play an important part in the life of the school population and can also supplement the work of the nursing teams in caring for families, but this must be done as part of total care with full co-operation between everyone involved."

MEDICAL EXAMINATION OF TEACHERS

Full medical examinations (including chest X-ray) are required for certain teaching appointments, and for those either taking up a teaching post for the first time or who have had a break in service for a period of 12 months or more; the number o fsuch examinations during the year was 24.

For teaching appointments other than above, the completion of a questionnaire and submission of a certificate of satisfactory chest X-rav is all that is required, and from the information supplied by the candidate an assessment is made whether a medical examination is necessary. During the year 251 such questionnaires were completed.

In addition, 284 medical examinations were carried out of candidates for entry to teacher training colleges.

Mr. Gordon S. Bessey, Director of Education, has supplied the following notes on school premises, meals and milk:

School Premises

The undermentioned twelve primary schools were closed during the year

Bromfield
Calderbridge C. of E.
Ellenborough County Infant
Ellenborough C. of E. Junior
Gamblesby
Grasslot
Millom Boys
Millom Girls
Nether Denton
Piperstile
Waverbridge
Waverton

Three new primary schools were opened:—

Millom, Black Combe Junior
Maryport, Ewanrigg Infant
Maryport, Ewanrigg Junior

At the very end of the year, the Aspatria Mixed and Infant Schools were amalgamated.

Large extensions were completed at the following secondary schools:—

Dalston, Caldew
Maryport, Netherhall
Penrith Tynefield
Penrith, Ullswater

The heating systems of the undermentioned schools and kitchens were converted from coke to automatic fuels:—

Brampton Infants
Great Corby
Penrith County Boys
Penrith County Girls
Penrith, St. Andrews Boys
Penrith, Queen Elizabeth Grammer
Wigton St Cuthberts R.C.
Burgh-bySands
Dalston, St. Michaels C. of E.
Alston Primary
Cockermouth Grammar
Kells Infants
Keswick
Monkwray Junior
Moor Row
Whitehaven Richmond
Whitehaven St Begh's R.C. Sec.
Whitehaven Bransty
Whitehaven Crosthwaite Memorial
Workington St. Michael's Infants
Workington St. Patrick's R.C. Junior
Cleator County
Cleator Moor St. Patrick's R.C.
Silloth Junior
Aspatria Central Kitchen
Armathwaite
Holme Cultram Abbey C. of E.
Blencogo C. of E.
Bridekirk Dovenby
Bootle Capt. Shaws
Brigham St Bridgets C. of E.
Embleton
Crosby-on-Eden C. of E.
Cummersdale
Dearham
Ennerdale
Great Clifton
Hayton C. of E.
Rockcliffe
Thwaites
Lees Hill C. of E.
Eaglesfield Paddle
Broughton Moor
Waberthwaite C. of E.
Maryport Nursery
Great Orton
Stainburn Central Kitchen
Wigton Central Kitchen
Hensingham Central Kitchen
Penrith Central Kitchen
Silloth Kitchen

High Hesket C. of E. School was extended and new premises provided for Fairfield Junior School, Cockermouth.

Aspatria Primary School and Wigton Infants School were remodelled.

A new kitchen was provided for Millom Infants School. A scullery was provided at Crosthwaite Old School, Keswick.

Temporary classrooms were provided at Crosthwaite Old School, Keswick and Harrington Infants School.

New and improved sanitation was provided at the undermentioned schools:—

Heating improvements were carried out at the undermentioned schools:—

Eden
Cockermouth Grammar
Wigton, Nelson Thomlinson
Penrith, Queen Elizabeth Grammar
Valley Junior, Whitehaven
Millom
Armathwaite
Gosforth C. of E.
Garth, Workington
Victoria Infants, Workington
Hayton C of E
Holme St , Cuthbert
Irthing Valley, Brampton
Longtown Junior and Infants
Renwick

The following schemes were carried out by the managers:

Lazonby C. of E.	Suspended ceilings and classrooms
	Remodelling and indoor toilets
	Completion of new premises
Workington St. Patrick's R.C.	Third instalment of new premises

School Meals

The figures below show the number of pupils taking a mid-day meal on a census day in September. The 1/9d. charge for a meal becomes 9p from 15th February, 1971 and 12p from the beginning of the summer term 1971.

PRIMARY AND NURSERY SCHOOLS

Year	Number of Children Present	Number Taking Meals	Percentage Taking Meals
1969	21,633	19,259	89.0
1970	21,107	18,794	89.0

SECONDARY SCHOOLS

Year	Number of Children Present	Number Taking Meals	Percentage Taking Meals
1969	14,942	13,598	91.0
1970	15,401	13,680	88.8

ALL SCHOOLS COMBINED

Year	Number of Children Present	Number Taking Meals	Percentage Taking Meals
1969	36,575	32,857	89.8
1970	36,508	32,474	88.9

During 1970 new kitchens were opened at:—

St. Bega's C. of E. School, Eskdale.
St. Bees Village School.
Blackcombe Junior School, Millom.
Millom Infant School.
St. Catherine's R.C. School, Penrith.
Ewanrigg Infant School, Maryport.
Ewanrigg Junior School, Maryport.

Milk in Schools

The figures below show the number of pupils in schools maintained by the authority taking milk on a census day in September. The provision of free milk to pupils over 7 years will stop at the end of the summer term 1971.

PRIMARY AND NURSERY AND SPECIAL SCHOOLS

Year	Number of Children Present	Number Taking Milk	Percentage Taking Milk
1969	21,731	19,086	87.8
1970	21,205	18,594	87.6

The percentages of pupils taking pasteurised milk and untreated milk are as follows:—

Year	Pasteurised	Untreated
1969	96%	4%
1970	96%	4%

APPENDIX 'A'

Report upon Physical Education for the year ended 31st December, 1970

The attitude and pattern of approach of physical educationists over the past decade have deeply influenced the understanding of the physical, mental and spiritual needs of the school child, the school leaver and the young adult. Formality and the imposition of ideas have given way to guidance, along with the opportunity for experiment and self-expression, while the field of recreational activity has been

considerably widened to include pursuits previously enjoyed by the few. In this latter respect, with the realisation that activities such as badminton, golf sailing, ski-ing, squash, etc. have greater social appeal and are much more likely to be pursued after leaving school than the traditional major sports, much has been done to foster an interest in these and other recreational subjects for older pupils. The wide choice offered has led to changes in the planning of curricula, bring opportunity for adventure at home and abroad, re-adjustment of ideas upon buildings to incorporate social recreation for the 1970's and the development of the community school.

Community swimming pools (Lazonby, Brampton, Cleator Moor, Egremont, Maryport, Workington), sports halls (Egremont, Workington, Whitehaven, Wigton, Dalston), climbing walls (Penrith, Longtown, Aspatria, Wigton, Whitehaven, Workington, Dalston), secondary school gymnasia and halls, all-weather areas (Egremont, Workington, Whitehaven), secondary school playing fields, ski-slope (Cleator Moor) and squash courts (Brampton, Egremont, Wigton) are providing media whereby it is now possible, through joint provision and dual-use, to foster a much closer link between the school and the community. This is of reciprocal benefit to both school and post school users and it offers the opportunity of establishing continuity in participation in physical recreation from school through youth to adult level. It also initiates an interest in school leavers by adult clubs; thus opening the door to recreation in post school years.

Cumberland teachers, being fully aware of the philosophy underlying community schools, continue to develop a physical education programme which not only meets the needs of children during school life but also lays the foundation for extension and development in post school years of those activities which will satisfy their inclination when adults. These programmes take into account the basic elements of interest, breadth and variety of activity, personal choice and satisfaction so that towards the end of school life a pupil's interest has been captured sufficiently to pursue his special activity into adult life, be it sailing, canoeing, climbing, dancing, team games or other forms of recreational pursuit. However, in addition to the wide programme of "options" offered to older secondary school pupils, traditional activities such as educational gymnastics, swimming and major games are still followed vigorously by other pupils as basic training. To these activities have been added educational dance, olympic gymnastics and trampolining.

In the Primary School, where so many new developments in education begin, physical education has become a shared experience between child and teacher. Over the year it has continued to flourish and improve as more new schools are built, and old ones are altered to provide good facilities, thus enabling a full and varied programme to be carried out.

Primary School teachers, for whom specialist training in physical education is exceptional, continue to seek and to accept guidance. The friendly atmosphere in our schools makes for an easy working relationship between teacher and adviser which is of tremendous importance, and which has an equally important effect on the attitude of the children towards the varied working situations in school.

The enthusiasm of the teachers was very evident at a dance course held at the Teachers' Centre in Wigton in November. The course was well attended, and everyone took part whether they felt qualified to describe themselves as dancers or not! A great deal of hilarity punctuated the proceedings, notwithstanding the odd groan as unaccustomed muscles went into action.

The purchase of a copy of the Schools' Council P.E. film, "Free to Move", by the Authority, has aroused considerable interest, and one showing at a Primary School in Penrith in December attracted a very large audience. Arrangements have been made to show the film four more times in the new year at Teachers' Centres, and it is expected that there will be many more requests to see thefilm.

Swimming

The Cumberland Schools' Swimming Association held its County Championships in Carlisle this year, and it was apparent that the standard of swimming at this level continues to improve.

The Divisional Gala was at Ellesmere Port, Cumberland entered thirteen swimmers, and gained one 1st place and one 2nd, five 3rd and five 4th places, and one 5th place. Wendy Burrell and Susan Fyfe also swam at Plymouth for the Division, where Wendy broke the National Schools' backstroke record.

An A.S.A. Teachers' course was held in Carlisle, taken by Hamilton Bland, the A.S.A. Northern area Technical Officer, the successful candidates adding to the strength of qualified teachers in the county.

In February, Helen Elkington, National Technical Officer for the A.S.A., took a course on Synchronized Swimming for teachers from the city and the county. The course was well attended, and this new side of swimming aroused considerable interest.

Miss Elkington's visit to Cumberland also provided the opportunity for two days of swimming coaching with schoolchildren, at Overend and Netherhall.

In addition to swimming, many outdoor pursuits are concerned with the use of water and possess, therefore, a common built-in danger — DROWNING. In order to assist teachers and others concerned with water recreation to render assistance should the need arise, a one-day conference upon resuscitation was arranged in conjunction with the Royal Life Saving Society, the County Medical Staff and the County Ambulance Service at Netherhall School in May. The conference, which was concerned with all forms of artificial respiration, including the use of oxygen, was addressed by Dr. J. D. Terrell, Deputy County Medical Officer, Dr. A. Ward, Consultant Anaesthetist and Mr. G. Donald, National Technical Officer, R.L.S.S. As a follow-up to the county conference regular six monthly local refrsher courses are arranged at Further Education Centres, when practice in resuscitation techniques may be revised under the guidance of ambulance officers.

Hockey

The Cumberland Schools Open Tournament was held in Wigton in March and was won by Cockermouth G.S. The second annual tournament in October had to be cancelled due to torrential rain, and an alternative date is to be fixed for early in 1971.

The county Junior teams had some good matches with close results. The 1st XI won one, drew one and lost two matches, and the 2nd XI won one, drew one, and lost one match.

A coaching course was held in October, taken by two England players, Mrs. V. Nolan and Miss M. Birtwistle.

Netball

This season, so far, has been more successful than ever for our county teams, with eight wins out of twelve matches against teams from Durham, Newcastle and Lancaster.

One of our under-21 players was invited to the All England Netball Association trials in London in November and succeeded in reaching the last fourteen players selected, a very notable achievement.

The County Netball Tournament was held in Carlisle in November, when a record number of schools took part in both sections. The four winning teams will go through to the second round, in Hull, in January.

A coaching course on the rules of Netball was held in November.

Table Tennis

As far as the County School's Association is concerned, a much more positive effort is being made to put the association on a sounder basis. To this end a general meeting is to be held in April next year to establish a constitution.

The annual schools' tournament was held at Overend School on May 2nd, when 71 boys and girls from 15 secondary schools within the county took part.

In October every secondary school received a circular with a view to forming a Schools' league. Twelve replies were received and it was found that it was possible to operate a league from schools mainly in the Whitehaven area. These fixtures are now under way.

A Schools' Table Tennis Centre has been established at Overend School, equipped with four new Dunlop tables. This is operating under the guidance of Mr. R. Rigg, the secretary of the County Table Tennis Association, and coaching is freely available to pupils from other schools.

Association Football

Potential county players in the Under-19 and Under-15 groups have been coached on a number of evening and Saturday sessions spread over the year in East and West Cumberland, to be followed by the annual coaching courses for the two groups at Caldew School in March and October. County games, preceeded by regular intensive coaching of teams, have been held against South West Scotland, Ayrshire, North Lancashire, Staffordshire and Cheshire, with the honours being fairly evenly divided.

Athletics

Following an undulating pattern of development of events over the year, with cross-country championships for boys and girls, coaching courses for promising athletes, the County Championships held at Whitehaven (when seventeen records were broken) and the Triangular Match at Stanley (when Cumberland came second), the season flowered into the most successful cascade of achievements Cumberland Schools' Athletic Association has experienced over the past 40 years. In addition to two National Champions (C. Eyre and D. Thompson) and six E.S.A.A. Standard Badges the following three National Trophies were won:—

Minor Counties Aggregate Track Event Trophy with 23 points

Minor Counties Aggregate Relay Events Trophy with 7 points

Senior Boys' Race - Walk Trophy with 7 points.

Subsequently, C. Eyre became a Gt. Britain Junior International in the Race - Walk event.

Cricket

The Junior Section's Easter Coaching Course was held at the Carlisle Sports Centre following which a team was selected to meet Northumberland, Yorkshire, Lancashire and Cheshire. Andrew Kennaugh was selected for the North of England team in the E.S.C.A. Festival at Norwich. An Under 13 XI has been instituted and the enthusiasm shown by these youngsters, both at the coaching course held at Moorclose at Whitsuntide, and at the subsequent "county" game against a St. Bees XI promises well for the future of cricket in Cumberland.

Mr. G. W. Scott has been elected Vice-Chairman of the E.S.C.A. and will automatically become Chairman of the national body during the Twenty-first anniversary year of the County Association.

The Senior Section has been sadly handicapped through a lack of bowling ability. The Hon. Secretary reports "Unless better wickets are provided at our schools so that boys may master the skills of bowling, the twin Counties will always be at the receiving end when they play other County or Senior Club XI's."

Ten County games were played, mainly during the August holidays, of which seven were lost and three drawn. Only on one occasion was the County XI dismissed for less than 100 runs.

G. McMeekin and G. Raven represented England during the season.

Olympic Gymnastics

Olympic gymnastics is a sport demanding, in addition to natural ability, considerable hard work, coaching and movement analysis. These factors, together with the widening of the physical education programme and the rapid raising of standards nationally in a relatively new sport in schools, have led to a reduction in participation. The Under 13 Championships were held at Caldew School in February, bein won by Moorclose School and the Under 15 Championships were won by Caldew, at Caldew, in December. In March an Under 13 County Team travelled to Newcastle to have an enjoyable and victorious encounter with the Royal Grammar School.

Rugby Union

The outstanding feature of the 1969/70 season was the success of the 15 Group who won all eight of their county games, with 155 points against 55. Ian Crellin gained an international cap. In complete contrast, the 1970/71 season shows defeat at the hands of both Durham and Northumberland, largely the result of weakness in the basic skills of the game. It is pleasing to note that these errors are now being rectified in schools and, as a result, victories have been gained against South West Scotland and North Yorkshire.

The 19 Group have shown considerable improvement over last year's team, winning three and drawing one of their four games.

The year has seen the introduction of an Under 13 competition with twelve schools participating, a move which should be wholly for the good of the game.

Relationships with the senior union continue to be most cordial; the encouragement and help from senior clubs is greatly appreciated by teachers.

Rugby League

In spite of rugby league football having a relatively small following in West Cumberland the standard of the game has improved to such an extent in schools that the county side has come within two points of beating the full Yorkshire team.

During the Easter holiday three French teams from Roanne visited Cumberland to receive civic hospitality at Workington, Whitehaven and at The Courts, Carlisle, gestures which were greatly appreciated by Cumberland teachers. We hope our foreign guests did not feel too dejected at losing the three games which were arranged for this third annual exchange. The Chairman, Mr. R. Morgan, has been elected Chairman of the English Schools' Rugby League.

Outdoor Activities

To the broad spectrum of open country pursuits has now been added that of orienteering, pioneered this year at Ehenside School. This relatively new sport using map and compass has fired the imagination of many youngsters and adults alike who take advantage of the opportunities which our beautiful Cumberland countryside has to offer. The dry ski-slope owned by West Cumberland Ski Club has now become a joint venture with the Education Authority who have made a grant towards its extension. Many Cumberland children and young people learn to ski on this slope at Cleator and have been quick to benefit further from the snows of 1970, both in Cumberland and over the Border.

Other pursuits such as rock-climbing, mountaineering, canoeing and sailing continue to be followed with avid enthusiasm in the evenings, at week-ends and during holiday time, through excursions, camps and residence at the outdoor pursuits centres owned by the Cumberland Authority. It is pleasing to note that in Conservation Year 1970 many teachers have appreciated the close link between open country pursuits and the need for education in the correct use and conservation of the natural environment, using the former as a vehicle for the promotion of the latter. It is hoped that outdoor activities of all types will continue to be developed as a means of incidental education inenvironmental understanding, as "pressure points" in the appreciation of the greatest human problem of our time.

APPENDIX B
TABLE A—Periodic Medical Inspections

Age Groups inspected (By year of birth) (1)	No. of Pupils who have received a full medical examination. (2)	PHYSICAL CONDITION OF PUPILS INSPECTED Satisfactory No. (3)	Unsatisfactory No. (4)	No. of Pupils found not to warrant a medical examination (See Note 1 above) (5)	Pupils found to require treatment (excluding dental diseases and infestation with vermin) For defective vision (excluding squint) (6)	For any other condition recorded at Part II (7)	Total individual pupils (8)
1966 and later	62	62	—	—	—	2	2
1965	2205	2205	—	—	46	159	200
1964	1446	1446	2	—	38	124	160
1963	216	216	1	—	6	8	13
1962	975	975	—	2038	58	82	137
1961	149	149	—	287	7	11	17
1960	78	78	—	—	7	7	12
1959	104	104	—	515	7	7	13
1958	646	646	—	1817	42	68	109
1957	176	176	—	473	17	15	31
1956	2479	2479	—	—	76	74	149
1955 and earlier	631	631	—	—	35	27	61
TOTAL	9167	9167	3	5130	339	584	904

Table B—Other Inspections

Number of Special Inspections	118
Number of Re-inspections	5558
Total	5676

Table C—Infection with Vermin

(a) Total number of individual examinations of pupils in schools by school nurses or other authorised persons	51207
(b) Total number of individual pupils found to be infested	796
(c) Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	2
(d) Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	—

Table D—Screening Tests of Vision and Hearing

1.	(a) Is the vision of entrants tested as a routine within their first year at school?	Yes.
	(b) If not, at what age is the first routine test carried out?	—
2.	At what age(s) is vision testing repeated during a child's school life?	At ages 8, 12 and 15.
3.	(a) Is colour vision testing undertaken?	Yes.
	(b) If so, at what age?	15. When choice of occupation or career.
	(c) Are both boys and girls tested?	Yes.
4.	(a) By whom is vision testing carried out? ...	School medical officers and school nurses. Screening Assistants.
	(b) By whom is colour vision testing carried out?	School medical officers and school nurses.
5.	(a) Is routine audiometric testing of entrants carried out within their first year at school? ...	Yes.
	(b) If not, at what age is the first routine audiometric test carried out?	—
	(c) By whom is audiometric testing carried out?	Screening Assistants.

Part II—Defects found by Periodic and Special Medical Inspections during the Year

Defect Code No.	Defects or Disease	PERIODIC INSPECTIONS Entrants (T)	Entrants (O)	Leavers (T)	Leavers (O)	Others (T)	Others (O)	Total (T)	Total (O)	Special Inspection (T)	Special Inspection (O)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
4	Skin	20	59	11	41	26	95	57	195	1	2
5	Eyes—a. Vision ...	79	274	90	371	169	718	333	1363	10	5
	b. Squint ...	17	55	1	20	8	27	26	102	—	—
	c. Other ...	6	19	3	5	9	12	18	36	—	—
6	Ears—a. Hearing ...	61	235	17	39	65	210	143	484	—	—
	b. Ottis Media	9	90	4	4	5	37	18	131	—	—
	c. Other ...	7	37	3	1	4	24	14	62	—	—
7	Nose and Throat ...	24	385	7	56	17	150	48	591	—	—
8	Speech	51	101	1	10	21	56	73	167	2	—
9	Lymphatic Glands	—	70	—	3	1	15	1	88	—	—
10	Heart	8	65	4	37	1	51	13	153	—	—
11	Lungs	11	177	3	54	7	157	21	388	—	—
12	Developmental—										
	a. Hernia ...	3	9	—	2	—	19	3	30	—	—
	b. Other ...	11	106	1	13	6	65	18	184	1	—
13	Orthopeadic—										
	a. Posture ...	—	8	—	6	—	5	—	19	—	—
	b. Feet	33	83	5	15	8	59	46	157	—	1
	c. Other ...	6	76	1	35	7	79	14	190	—	—
14	Nervous System—										
	a. Epilepsy ..	—	9	—	3	—	15	—	27	—	—
	b. Other ...	3	44	1	8	1	44	5	96	—	—
15	Psychological—										
	a. Development	6	85	1	15	9	114	16	214	1	—
	b. Stability	10	219	3	24	21	221	34	464	—	—
16	Abdomen	4	40	—	30	1	39	5	109	—	—
17	Other	5	102	11	110	19	146	35	358	—	3

Part III—Treatment of Pupils attending maintained Primary and Secondary Schools (including Nursery and Special Schools)

Table A—Eye Diseases, Defective Vision and Squint

	Number of cases known to have been dealt with
External and other, excluding errors of refraction and squint	—
Errors of refraction (including squint) ...	2799
Total	2799
Number of pupils for whom spectacles were prescribed	1279

Table B—Diseases and Defects of Ear, Nose and Throat

	Number of cases known to have been dealt with
Received operative treatment—	
(a) for diseases of the ear	5
(b) for adenoids & chronic tonsillitis	52
(c) for other nose and throat conditions	2
Received other forms of treatment ...	53
Total	112
Total number of pupils in schools who are known to have been provided with hearing aids:—	
(a) in 1970	17
(b) in previous years	73

Table C—Orthopaedic and Postural Defects

	Number of cases known to have been dealt with
(a) Pupils treated at clinics or out-patients departments	197
(b) Pupils treated at school for postural defects	123
Total	320

Table D—Diseases of the Skin

(excluding uncleanliness, for which see Table C of Part I)

	Number of cases known to have been dealt with
Ringworm—(a) Scalp	—
(b) Body	—
Scabies	173
Impetigo	23
Other skin diseases	40
Total	236

Table E—Child Guidance Treatment

	Number of cases known to have been dealt with
Pupils treated at Child Guidance Clinics	142

Table F—Speech Therapy

	Number of cases known to have been dealt with
Pupils treated by speech therapists ..	493

Table G—Other Treatment Given

	Number of cases known to have been dealt with
(a) Pupils with minor ailments ...	3
(b) Pupils who received convalescent treatment under School Health Service Arrangements	19
(c) Pupils who received B.C.G vaccination	2755
(d) Other than (a), (b), and (c) above	—
Total (a)—(d)	2777

Part IV — Dental Inspection and Treatment carried out by the Authority

1. Attendances and Treatment.

	Ages 5 to 9	Ages 10 to 14	Ages 15 and over	Total
First Visit	5,037	5,033	1,156	11,226
Subsequent Visits ...	4,513	7,388	1,605	13,506
Total Visits	9,550	12,421	2,761	24,732
Additional courses of treatment commenced	91	141	56	288
Total courses commenced ...	5,037	5,033	1,156	11,226
Courses completed				6,719
Fillings in permanent teeth	2,532	9,678	3,130	15,340
Fillings in deciduous teeth	3,263	355	—	3,618
Permanent teeth filled	2,044	8,519	2,797	13,360
Deciduous teeth filled	3,031	320	—	3,351
Permanent teeth extracted	695	2,609	569	3,873
Deciduous teeth extracted	6,574	1,767	—	8,341
General anaesthetics	1,592	910	84	2,586
Emergencies	867	499	190	1,556
Number of Pupils X-rayed ...		...	...	281
Prophylaxis		...	...	441
Teeth otherwise conserved		...	...	760
Number of teeth root filled		...	...	28
Inlays		...	...	6
Crowns		...	...	17

2. Orthodontics.

New cases commenced during the year	127
Cases completed during the year	90
Cases discontinued during the year	6
Number of removable appliances fitted	213
Number of pupils referred to Hospital Consultants	224

3. Prostnetics.

	5 to 9	10 to 14	15 and over	Total
Number of pupils fitted with dentures for the first time ...	—	—	—	—
Pupils supplied with full dentures ...	—	4	3	7
Pupils supplied with other dentures ..	4	59	36	99
Number of dentures supplied	4	63	39	106
Number of dentures supplied first or subsequent time	6	98	66	170

4. Anaesthetics.

General anaesthetics administered by Dental Officers ... 2,133

5. Sessions.

Number of clinical sessions worked in the year.

	School Service			M. and C.W. Service			
	Admin. Sessions	Inspections at school	Treatments	Dental Health Education	Treatments	Dental Health Education	Total Sessions
Dental Officers	275	230	3,270	4	110	—	3,889
Dental Auxiliaries ...	—	—	269	14	—	—	283
Total ...	275	230	3,539	18	110	—	4,172

APPENDIX C.

Handicapped Pupils requiring Education at Special Schools approved under Section 9(5) of the Education Act, 1944, or Boarding in Boarding Homes

During the calendar year ended 31st December, 1970:—		(1) Blind (2) Partially sighted		(3) Deaf (4) Partial hearing		(5) Physically Handicapped (6) Delicate		(7) Mal-adjusted (8) E.S.N.		(9) (10) Epileptic Speech Defects		Total Cols. (1)-(10)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
A. How many handicapped children were newly assessed as needing special educational treatment at special schools or in boarding homes?	boys	—	—	1	—	1	—	5	36	—	—	43
	girls	—	—	1	—	—	—	—	22	—	—	23
B. How many children were newly placed in special schools (other than hospital special schools) or boarding homes?												
(i) of those included at A above	boys	—	—	—	—	1	—	1	7	—	—	9
	girls	—	—	—	—	—	—	—	6	—	—	6
(ii) of those assessed prior to January, 1970	boys	—	—	—	1	—	—	—	9	—	—	10
	girls	—	—	—	—	—	—	1	5	—	—	6
(iii) TOTAL newly placed— B(i) and (ii)	boys	—	—	—	1	1	—	1	16	—	—	19
	girls	—	—	—	—	—	—	1	11	—	—	12

PART II

Children found unsuitable for education at school

During the calendar year ended 31st December, 1970:—

(i) how many children were the subject of new decisions recorded under Section 57 of the Education Act 1944? ... 9

(ii) how many reviews were carried out under the provisions of Section 57A of the Education Act 1944? 3

(iii) how many decisions were cancelled under Section 57A (2) of the Education Act 1944? ..... —

Handicapped Pupils awaiting places in Special Schools or receiving Education in Special Schools; Independent Schools; in Special Classes and Units; under Section 56 of the Education Act, 1944: and Boarded in Homes.

As at 22nd January, 1970:—		(1) Blind (2) Partially sighted	(3) Deaf (4) Partial hearing	(5) Physically Handicapped (6) Delicate	(7) Maladjusted (8) E.S.N.	(9) Epileptic (10) Speech Defects	Total Cols. (1)-(10)
		(1) (2)	(3) (4)	(5) (6)	(7) (8)	(9) (10)	(11)
A. How many children from the Authority's area were awtiting places in special schools other than hospital special schools?							
(1) Under 5 years of age							
(i) waiting before 1st January, 1970:—							
(a) day places	Boys	— —	— —	— —	— —	— —	—
	Girls	— —	— —	— —	— —	— —	—
(b) boarding places	Boys	— —	— —	— —	— —	— —	—
	Girls	— —	— —	— —	— —	— —	—
(ii) newly assessed since 1st January, 1970:—							
(a) day places	Boys	— —	— —	— —	— —	— —	—
	Girls	— —	— —	— —	— —	— —	—
(b) boarding places	Boys	— —	1 —	— —	— —	— —	1
	Girls	— —	— —	— —	— —	— —	—
(2) Aged 5 years and over							
(i) waiting before 1st January, 1970:—							
(a) whose parents had refused consent to their admission to a special school—							
(a) day places	Boys	— —	— —	— —	— 2	— —	2
	Girls	— —	— —	— —	— 14	— —	15
(a) day places	Boys	— 1	— —	— 1	— 16	— —	18
	Girls	— —	1 —	— —	— —	— —	1

(b) others												
(a) day places	boys	—	—	—	—	—	—	—	5	—	—	5
	girls	—	—	—	—	—	—	—	12	—	—	12
(b) boarding places	boys	—	—	—	—	—	—	—	27	—	—	27
	girls	—	—	—	—	—	—	—	16	—	—	16
(ii) newly assessed since 1st January, 1970:—												
(a) whose parents had refused consent to their admission to a special school												
(a) day places	boys	—	—	—	—	—	—	—	—	—	—	—
	girls	—	—	—	—	—	—	—	—	—	—	—
(b) boarding places	boys	—	—	—	—	—	—	—	—	—	—	—
	girls	—	—	—	—	—	—	1	—	—	—	1
(b) others												
(a) day places	boys	—	—	—	—	—	—	—	2	—	—	2
	girls	—	—	—	—	—	—	—	2	—	—	2
(b) boarding places	boys	—	—	—	—	1	—	4	27	—	—	32
	girls	—	—	1	—	—	—	—	13	—	—	14
(3) Total number of children awaiting admission to special schools other than hospital special schools—total of (1) and (2) above												
(a) day places	boys	—	—	—	—	—	—	—	7	—	—	7
	girls	—	—	—	—	—	—	—	16	—	—	16
(b) boarding places	boys	—	4	—	1	1	—	4	68	—	—	78
	girls	—	—	—	2	1	—	—	46	—	—	49

B. How many pupils from the Authority's area were on the registers of:—

(i) Maintained special schools (other than hospital special schools and special units and classes not forming part of a special school) regardless by what authority they are maintained.	boys	—	—	—	—	1	—	—	—	—	—	1
	girls	—	—	—	—	—	—	—	—	—	—	—
day	boys	—	—	—	1	1	—	—	60	—	—	62
boarding	girls	—	—	—	—	—	—	—	35	—	—	35
(ii) Non-maintained special schools (other than hospital units and classes not forming part of a special school) wherever situated.	boys	—	—	—	—	—	—	—	—	—	—	—
	girls	—	—	—	—	—	—	—	—	—	—	—
day	boys	4	—	7	4	2	—	—	—	—	—	17
boarding	girls	1	3	6	3	1	—	—	1	—	—	15
(iii) Independent schools under arrangements made by the authority.	boys	—	—	—	—	3	—	—	—	—	—	3
	girls	—	—	—	—	—	—	—	—	—	—	—
day	boys	—	—	—	—	3	—	—	—	—	—	3
boarding	girls	—	—	—	—	—	—	—	1	—	—	1
(iv) Special classes and units not forming part of a special school.	boys	—	—	—	—	—	—	—	—	—	—	—
	girls	—	—	—	—	—	—	—	—	—	—	—

C. How many children from the Authority's area were boarded in homes and not already included in B above.	boys	—	—	—	—	—	—	1	—	—	—	1
	girls	—	—	—	—	—	—	—	—	—	—	—
D. How many handicapped pupils (irrespective of the area to which they belong) were being educated under arrangements made by the authority in accordance with Section 56 of the Education Act, 1944.												
(i) in hospitals	boys	—	—	—	—	—	—	—	—	—	—	—
	girls	—	—	—	—	—	—	—	—	—	—	—
(ii) in other groups, e.g. units for spastics, etc.	boys	—	—	—	—	—	—	—	—	—	—	—
	girls	—	—	—	—	—	—	—	—	—	—	—
(iii) at home	boys	—	1	—	—	—	—	—	—	—	—	1
	girls	—	—	—	—	—	—	—	—	—	—	—
E. Total number of handicapped children requiring places in special schools; receiving education in special schools; independent schools; special classes and units; under Section 56 of the Education Act 1944; and boarded in Homes.	boys	4	5	8	5	11	—	5	128	—	—	166
	girls	1	3	8	3	2	—	1	82	—	—	100

APPENDIX D.

SCHOOL HEALTH SERVICE CLINIC AS AT 31.12.70

(Actual school clinic work as distinct from special clinics is being carried out either in conjunction with chld welfare clinic sessions or as specially required).

ALSTON:
Dental—2nd and 4th Tuesdays—all day

ASPATRIA:
Dental—Each Friday—all day
Speech Therapy—Each Thursday — all day alternate Fridays.

BRAMPTON:
Dental—each Tuesday, each Wednesday—all day.

CARLISLE:
Dental—Each Monday and Friday—all day.
Eye Specialist—Each Wednesday and Thursday a.m.
Orthoptic—Each Monday a.m.
Child Guidance—Each Monday—all day.
Speech Therapy—Each Tuesday a.m. and Thursday a.m.
If required, each Tuesday p.m.
Orthopaedic Aftercare—Each Wednesday as required.

CLEATOR MOOR:
Dental—Each Monday and Wednesday—all day.

COCKERMOUTH:
Dental—Monday, Tuesday and Friday—all day.
Speech Therapy—Each Wednesday a.m.
Hospital Eye Clinic—2nd Friday a.m

EGREMONT:
Dental—Each Monday and Friday—all day.

KESWICK:
Dental—Thursday—all day.
Speech Therapy—Each Wednesday p.m.
Hospital Eye Clinic—1st Wednesday p.m.

LONGTOWN:
Dental—Thursday—all day.
Speech Therapy—Each Wednesday p.m.
Hospital Eye Clinic—1st Wednesday p.m

LONGTOWN:
Dental: Each Monday, all day. Each Thursday, all day.

MARYPORT:
Dental—Each Wednesday and Thursday and Friday—all day
Speech Therapy—Monday—all day.
Child Guidance—Alternate Monday p.m.

MILLOM.
Dental—Each Tuesday and Wednesday—all day.
Child Guidance—Thursday p.m. as required.
Eye Specialist—1st and 3rd and 4th Friday—all day.
Speech Therapy—Each Monday and Thursday a.m.

PENRITH:
Dental—1st and 3rd and 5th Tuesday—all day.
Each Wednesday—Thursday and Friday all day.
Speech Therapy—Each Tuesday and Thursday, all day.
Orthoptic—Each Wednesday—all day.

SEASCALE:
Dental—Each Thursday—all day.

SALTERBECK:
Dental—Each Tuesday, Thursday and Friday—all day.

SILLOTH:
Dental—Each Thursday—all day.

WHITEHAVEN (FLATT WALKS):
Dental—Each Monday, Tuesday, Wednesday, Thursday and Friday—all day.
Whitehaven Grammar School—Each Wednesday — all day.
School each Wednesday morning.
Child Guidance—Each Wednesday p.m. attended by Dr. Ferguson.

WIGTON:
Dental—Each Monday and Tuesday—all day.
Speech Therapy—Each Friday a.m.

WORKINGTON (PARK LANE):
Dental—Each Monday, Tuesday and Thursday — all day.
Wednesday and Friday by appointment
Speech Therapy—Each Monday and Tuesday—all day.
Wednesday p.m. Thursday—all day
Child Guidance—Each Wednesday a m.

WORKINGTON INFIRMARY:
Monday—all day. Tuesday p.m. Thursday a.m.